Trauma Matters

Spring 2018

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

Inside this issue:

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www.womensconsortium.org

Connecticut's Push for Trauma-Informed, Gender-Responsive Care: One Large Agency's Experience

It has been five years since Community Health Resources (CHR) joined the Trauma and Gender Practice Improvement Collaborative (TAG) sponsored by Connecticut Women's Consortium and Connecticut Department of Mental Health and Addiction Services. As one of the larger non-profit behavioral health agencies in the state, we have over 700 employees, 50 programs and more than 30 sites; thus, incorporating TAG throughout the system presented a number of unique challenges.

The key to our success was the active involvement of leadership at all levels of the organization starting with the CEO, in addition to thinking and experimenting with staff and client communication. This was a system wide performance improvement project which led to the examination and review of almost every aspect of the care we provided. Our successes and level of involvement in the project varied from program to program and site to site. In areas where leaders became engaged with the program, encouraging staff to use the TAG framework to look intensively at the services they provide, TAG led to fundamental changes in care.

There is a clearer fit between the principles of TAG and the priorities of some of our funders over others. For example, our women's residential program for substance use and our outpatient programs were a natural fit given their background of focusing on an individual's trauma history. However, in contrast, programs funded by the judicial branch have a strong focus on community protection and a dual focus on punishment and treatment; by definition, clients in these programs have less choice and there is less of an overall emphasis on trustworthiness and collaboration, two of the essential values of TAG.

CHR had a decentralized approach with four local TAG steering committees which utilized staff and client surveys to develop work plans for their areas and reported back to the full agency-wide steering committee. Staff (across all levels) and consumers were involved in the steering committees, with the active involvement of Human Resources staff acting as a key component of the group. Intrinsic to the structure and a major goal of TAG was an emphasis on agency communications; with this in mind we used flyers, emails, local meetings, open houses, lunches with the CEO and more as a means to share information at each staff meeting.

During CHR's involvement with TAG, the agency was actively focused on trauma informed care at all levels. In addition to steering committee meetings, progress was reviewed regularly at executive team meetings and all staff meetings. Many discussions occurred around the TAG framework, looking at all aspects of care through the values of choice, safety, trustworthiness, collaboration and empowerment. Work plans ranged from small, concrete goals to larger initiatives including the following:

- Better signage in our buildings and placing signs about the TAG values across sites;
- Addressing poor lighting;
- Re-arranging waiting rooms and therapist offices;

(CT's Push for Trauma-Informed... Continued)

- Addressing insensitive language at team meetings and guiding documentation standards to ensure respectful language;
- Holding staff "town meetings".

Through the process, staff were actively encouraged to develop trauma-informed practices through the "TAG-You're It" incentive program and were honored for meeting TAG values. Human Resource policies were revised and TAG language was included in the staff evaluation format. All staff were trained in an introduction to trauma and trauma-informed care and we used a "train the trainer" model allowing us to have onsite trainers at many of our locations. Trauma and gender trainings were incorporated into staff orientation as well as ongoing staff trainings. Therapy staff were trained in Accelerated Resolution Therapy (ART) as well as a number of other evidence-based practices. In addition, gender specific groups and Intensive Outpatient Programs (IOPs) were established at all outpatient sites.

One palpable, but hard to measure, positive shift that was noted over time was the way staff talked about and with individuals receiving services. There was a clear shift in understanding and treating the link between trauma and substance use and a move away from the paradigm of blaming those who experience relapse. To better address trauma experienced by staff, a coordinated response was developed and implemented. TAG also inspired an initiative within CHR to grow our commitment to peer support. Over time, we realized that this would only succeed if we were able to provide a supportive infrastructure for our peer support employees and staff leading to another area of training, and eventually, the creation of a new agency wide position: Peer Support Coordinator.

I have often wondered why TAG was so successful in exciting and engaging so many of our staff while other, similar relational-centered initiatives were less successful. I have come to believe that it is TAG's focus on trauma as a lens through which to understand actions and behaviors and re-think service design resonated with our staff simply because it rang true with their own experiences, both personally and professionally. At the outset of TAG, we were encouraged to start thinking about and planning for the sustainability of the project. It is difficult to sustain the excitement and energy needed for an improvement project that engages all parts of a large agency like CHR. Although the everyday conversation has dissipated as have regular meetings of the various committees, many changes are still in place today. Some of these changes include:

- Potential hires are asked about their experience working with individuals who have trauma histories.
- New staff orientation includes sections on understanding trauma, trauma-informed care, and labelling/stigmatizing language.
- Staff evaluations include language about meeting core TAG values.
- Many individual programs remain focused on TAG values, discussing them at least on a weekly basis with both staff and clients; this is particularly true with our programs designed specifically for women.
- A large proportion of agency therapists are trained in trauma-specific treatment approaches and substance use services have a dual focus on trauma and substance use.
- There is a strong process for quickly informing staff of and responding to critical and traumatic incidents.
- Agency clubhouses continue to actively embrace TAG and the growth and strength of the agency peer support and recovery support services continue.

Perhaps the most enduring legacy of TAG is in the hearts and minds of those who actively participated and continue to look at and question the services provided every day through the lens of trauma-informed care.

Submitted by Stan Schapiro, LCSW
Stan coordinated TAG while he was the Senior Vice-President of CHR. He is presently a Behavioral Health Consultant.

Ask the Experts: A Conversation with Dr. Roger Solomon by Cheryl Kenn, LCSW

Dr. Roger Solomon is a psychologist and psychotherapist specializing in the areas of trauma and grief. He is on the Senior Faculty of the EMDR Institute in Warwick, Rhode Island and provides basic and advanced EMDR training internationally. He currently consults with the U.S. Senate, NASA, and several law enforcement agencies. Dr. Solomon has provided clinical services and training to the FBI, Secret Service, U.S. State Department, Diplomatic Security, Bureau of Alcohol, Tobacco, and Firearms, U.S. Department of Justice (U.S. Attorneys), and numerous state and local law enforcement organizations. Internationally, he consults with the Polizia di Stato in Italy. Moreover, Dr. Solomon has planned critical incident programs, provided training for peer support teams and has provided direct services following such tragedies as Hurricane Katrina, September 11 terrorist attacks, the loss of the Shuttle Columbia, and the Oklahoma City Bombing. Dr. Solomon has expertise in complex trauma, and collaborates with Onno van der Hart, Ph.D., and others on the utilization of EMDR as informed by The Theory of Structural Dissociation of the Personality (TDSP), in which a traumatizing event creates a division of personality. Together with Terese Rando, Ph.D., he has written two articles on EMDR and grief and is writing a book on EMDR and traumatic grief.

(Ask the Experts... Continued)

1. What is the most significant shift, change or revelation in your understanding of trauma that has occurred during your career?

I started my career when the field believed that talking about the trauma would prevent PTSD. Now we understand that a traumatic experience is maladaptively stored in the brain and talking alone is not sufficient for integration. Consequently, we need interventions that can access the trauma and change the way it is neurologically stored.

2. What do you consider to be the most helpful stabilization skill or tool to teach a trauma survivor?

There are many effective skills that are necessary, but if I had to choose between calming methods and mindfulness, I would have to go for mindfulness

3. What is something (idea/concept/skill/technique etc.) you think all-trauma focused clinicians should know?

Given that trauma is maladaptively stored in the brain, evidence based methodologies that can access and integrate these experiences such as Eye Movement Desensitization and Reprocessing (EMDR) are essential for trauma focused therapists. However, it is important that clinicians be knowledgeable about trauma, attachment issues and Phase Oriented Treatment (stabilization, memory work, personality re-integration) in order to understand clinical symptoms and their origins (e.g. memories that are maladaptively stored in the brain), and to appropriately pace treatment.

4. What advice would you recommend to therapists treating clients dealing with traumatic grief?

It is important to know about trauma and grief, and how they interact. Trauma can interfere with the grief work, and grief can interfere with trauma work.

The Polytrauma System of Care: An Integrated Approach to Treating Traumatic Brain Injuries in Veterans

It is currently estimated that 22% of veterans of the conflicts in Iraq and Afghanistan have a traumatic brain injury (TBI); a percentage that more than doubles what was seen in Vietnam veterans (Summerall, 2017). In response, the U.S. Department of Veterans Affairs Health Care System (VA HCS) has established a Polytrauma System of Care (PSC), an integrated system of specialized rehabilitation programs committed to serving veterans with concussions, TBIs, and other polytrauma injuries. The PSC offers an interdisciplinary approach to treatment, comprehensive rehab planning, trainings, clinical social work, RN case management services, patient and family education, as well as referrals.

Polytrauma refers to the multiple types of injuries sustained by service members, primarily those due to Improvised Explosive Devices (IEDs). These include concussions, TBIs, fractures, amputations, burns, soft tissue injuries, spinal cord injuries, hearing damage, visual impairments, and post-traumatic stress disorder (PTSD). Such injuries require both a specialized plan of care in the immediate recovery period, followed by a comprehensive continuum of integrated clinical and support services. Due to advances in personal protective armor, many more veterans survive the acute injury phase of these exposures; however, they may require long-term rehabilitative services.

Seriously injured veterans are typically transferred to one of five Polytrauma Rehabilitation Centers (PRC), which are located in Virginia, Florida, Minnesota, California, or Texas. They receive acute and comprehensive inpatient rehabilitation for their specific injuries. Injured veterans may later be transferred to a Polytrauma Network Site (PNS*)* closer to their homes for post-acute rehabilitation services. Each site coordinates rehab services within a Veterans Integrated Service Network (VISN*)*. There are 23 network areas in the U.S.; New England comprises one network with Boston as its network site.

In addition to the service areas noted above, the VA offers a Polytrauma Support Clinic Team (PSCT) of which there are 87 across the country. Within New England alone, there are seven PSCT's providing specialized outpatient rehab care; this care is comprised of outpatient Polytrauma and interdisciplinary evaluations, rehab plans of care, and case management. Since many of the polytrauma veterans are recently returning from combat or have recently separated from the military, many also have difficulty readjusting to civilian life. Struggling to cope with Polytrauma injuries can increase stressors and hinder successful reintegration. Identifying, diagnosing, and treating Polytrauma injuries, while also educating and supporting these veterans, requires a multidisciplinary approach relying on the expertise of many specialty services.

The polytrauma multi-disciplinary team in the VA CT falls under the direction of a Medical Director of Physical Rehab and Medicine (PM&R) and a Polytrauma Program Clinical Coordinator. The core team is comprised of several specialty treatment disciplines with support team members available, as well. Initial evaluation for exposure to head injury by the local support team is typically determined by a medical/mental health provider or via a referral from another VA facility. If deemed positive for a possible concussion, the veteran receives a polytrauma comprehensive evaluation to determine the severity of the polytrauma/concussion and initiate the Individualized Rehabilitation/Community Reintegration (IRCR) Plan of Care.

Concussions are defined as mild, moderate or severe. The majority of Veterans seen in VA CT HCS have experienced mild or moderate concussions. There is a smaller number of veterans with severe concussions; most are recently returning combat veterans with blast exposure or blunt trauma. There are also a significant number of veterans with non-combat related head injuries, including those due to motor vehicle accidents, assaults, and falls.

(The Polytrauma System of Care Continued)

During the comprehensive evaluation, the Physiatrist conducts a physical evaluation for musculoskeletal injuries or other physical injuries. The Polytrauma Clinical Coordinator or RN case manager complete a biopsychosocial assessment to identify areas of need related to 1) successful reintegration, 2) access to medical and financial resources, and 3) information on applying for Service Connected Disabilities (or other VA and non-VA resources that could offer assistance).

The Polytrauma Clinical Coordinator or RN case manager collaborates with the multidisciplinary team to initiate the Individualized Rehabilitation/Community Reintegration (IRCR) Plan of Care developed by the physician. Because polytrauma/TBI symptoms frequently overlap with PTSD and/or underlying mental health conditions, the team utilizes a holistic approach. Interventions are client-driven and goals include increasing functional independence and helping veterans manage responsibilities at home, school, work, and other functional environments. The team meets weekly to 1) review, discuss, and update each veteran's progress; 2) coordinate therapies and optimize ongoing education for the veteran about his or her specific injuries and treatment; and 3) respond to new problems that may emerge.

The IRCR also allows the team to address the emotional, cognitive and psychosocial needs of veterans, in addition to physical, medical, and neurological needs. For example, a symptom such as persistent headaches may not be due solely to neurological etiology; other contributing factors may be psychological stress, anxiety, muscle tension, and convergence insufficiency (a focal disorder that can be due to concussive injury to the musculature of the eye). Similarly, cognitive deficits, such as memory impairment, can be caused by neurological impairment, as well as PTSD and other mental health conditions. Specialized Occupational Therapists (OT) and Speech Therapists (ST) assist in determining whether symptoms are related to cognitive processing or organizational skills. Cognitive impairments can disrupt a veteran's ability to follow a daily schedule; OTs provide adaptive equipment with the goal of increasing functioning via 1) memory compensation techniques, organizational skills, and techniques to decrease distractions, 2) education on how emotions and sleep impact cognition, 3) anger management strategies and 4) coping skills.

Speech pathologists work with veteran polytrauma clients who have difficulties with speech, language, cognitive-communicative skills or swallowing. Cognitive-communicative impairments are a hallmark of TBI/concussions and are defined as problems with any aspect of communication caused by underlying deficits in cognition, such as attention, memory, and organization/problem-solving. Treatment of cognitive-communicative impairments focus on improving the patients functioning and may include attention process training, learning compensatory memory and organizational strategies and caregiver training.

Physical Therapists (PTs) evaluate and treat conditions such as myofascial pain syndrome, amputations, gait/balance disorders, deficits in range of motion and strength, poor posture, and vertigo. PTs evaluate and offer treatment that improve muscle function and decrease pain or promote healing. Examples of these modalities include electrical stimulation, ultrasound, manual therapy, vestibular therapy, cryotherapy, thermotherapy, assistive devices, and prosthetic and orthotic training.

Polytrauma Care includes a multidisciplinary assessment, acute treatment, and rehabilitative approach to recovery for TBI and all of its physical, trauma-related, emotional and behavioral complications.

Submitted by the following staff of VA CT:
Robieann Pecher MSW, LCSW
Sara Rubin, MD
Gene Bagnoli BSN, RN
Ms. Karen Le, PhD, CCC-SLP
Melissa Wells, PT, MSPT
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Using Neurobiology in Body-Focused Trauma Therapy

Individuals suffering from attachment related trauma often seek help because they find themselves overcome by feelings they can't explain. Following my own five-year psychoanalysis, a situation at work triggered a traumatic memory, and I had a panic attack. Even though I knew I was experiencing separation anxiety, I searched for an explanation that would stop the panic. Like my clients, my body's severe reaction blocked my ability to think clearly.

My personal evolution as a therapist changed when I learned that cognitive understanding was ineffective not only at stopping physical symptoms but emotional pain and suffering, as well. Neuroscience identifies ways to rewire our basic attachment and survival patterns that were negatively impacted by traumatic neglect and abuse in childhood. Dan Siegel (2003) asserts that neuroplasticity, or the ability to be rewired, introduces new ways to process trauma in therapy, so that rewiring can take place. Thus, using mindfulness and connecting with our bodies while recalling a traumatic event can be transformative.

In pursuit of a way to access symptoms held in the body, I was introduced to a touch-based therapy founded by Marion Rosen. Rosen was a physical therapist in Germany in the 1930's who developed a supportive relaxation technique to prepare patients prior to their psychoanalysis sessions; through this work, it was discovered that relaxing patients prior to psychoanalysis could accelerate recovery. Through the Rosen Method's chief objective, clients are instructed to redirect their awareness away from narrative and toward what is happening in the present in their bodies; to notice where muscles hold tension and observe what happens as they notice (Rosen, 2003).

Using my training in the Rosen Method, I shifted

(Using Neurobiology...Continued)

the focus of my work with clients to cultivate awareness of the body in the present moment. Once clients develop mindfulness, they can regulate their arousal and make more logical choices (Ogden, 2015; Siegel, 2003). My research has lead me to EMDR and, most recently, to neurobiologically-oriented treatment. Through these methods, I have seen how my clients can use awareness of their bodies to better handle daily life. Siegel (2003) explains that mindfulness helps unblock parts of the brain that prevent the digestion of feelings from childhood trauma, so clients no longer relive old memories, truly experiencing them as if they are in the past.

In order to better understand my evolution as a therapist from psychodynamic to body-centered and later neurobiologically informed, it may be helpful to look at a case study. Recently, a client asked for help with bouts of lethargy originating when he began living on his own. He expressed feelings of shame at his inability to create a schedule for consistent self-care. In separating out the physical elements he experienced each day, we found that he awoke with a feeling of dread connected to being alone and unseen; this was followed by feelings of lethargy and hypercritical thoughts of inadequacy and shame. We first linked the feelings to his childhood when he learned that asking for help would lead to shaming from his father.

Identified as one of the seven affective neuronal networks wired within the first year of development, "attach/cry for help" is defined by our initial attachment experience (Panksepp, 1998). Through failed experiences with family in early development, my client's wiring included messages to avoid crying or asking for help, contributing to a lack of assurance that he would be heard and comforted, something we know to be crucial for children to thrive. His new, daily experience of living alone triggered the body memory of being shamed and unable to ask for help in his developmental years.

Implicit and explicit memory are held in different parts of the brain. Implicit memory is located in the brain's right hemisphere and records sensations and responses while explicit memory processes sensory input like a cataloguing system in a library. When we are in danger, our alarm system shuts down all unnecessary parts of the brain that could impede our survival (McNally, 1997). The lethargy my client reported is caused by opioids released to block the extreme arousal and by the dorsal vagal system that shuts down fight/flight as well as attach/cry mechanisms (Lanius, 2014). His implicit memory retained the physical sensations (lethargy and shame) he felt when he needed help as a child but was too frightened of his father's response to ask. With this knowledge, my client can now remind himself that when he feels this way, he is actually experiencing a body memory from childhood causing him to feel lethargic and full of self-loathing. When he notices he feels confused, he understands his frontal lobe is shutting down, and he can employ alternative body-methods to self-soothe, thereby accessing his frontal cortex where his logic lives.

Frank Corrigan (2014) talks about shame as a jolt to the system followed by an urge to curl up and become invisible as a primal defense used by animals to stay out of sight from predators. Many clients suffer from severe shame in response to conflict; for example, another client of mine reported that she felt frozen and wanted to disappear when her daughter's mother-in-law verbally assaulted her. For two weeks, she couldn't stop crying, ruminating about feelings of humiliation. Focusing on what she felt in her body while she recounted the experience in therapy, she described a submit/shame response, which she recognized as how she coped as a child with a volatile and unpredictable mother. In the office, she practiced setting limits using sensory-motor exercises and observed her internal response change from a frightened child to a confident adult (Ogden, 2015; Fisher, 2011).

Clients with trauma histories very often do not have conscious memories to process but the symptoms and relational problems they experience contain implicit memories that can be evoked and processed during therapy. To work with implicit memories, clients need to be in their window of tolerance. Dan Siegel (2003) used this term to conceptualize the body's self-regulating system, showing a graph to track what triggers a client into hyper or hypo-arousal. Dissociation is the brain's effort to protect us when we cannot self-regulate, which happens when a client moves outside their window of tolerance. Fisher (2011) describes five dissociative patterns most trauma survivors experience when they become triggered: fight, flight, freeze, submit, shame and attach/cry, providing clients with an easy way to describe their dissociative patterns.

Discussions around the wiring of the brain and natural responses to trauma can provide clients a new framework within which to understand themselves. The key for me was to stop trying to reason with clients whose trauma shuts down the logical part of their minds and, instead, help them to work through these shutdowns. In summary, clients who previously felt crippled by physical symptoms from trauma can use tools from neurobiology to interrupt their negative response patterns. As therapists, we have the ability to use body-focused interventions as a means of facilitating change in our clients' very foundations.

Submitted by Daphne Kalaidjian, LICSW

April is...
National Child Abuse Prevention Month

This year, be a part of the solution.
Strong, nurturing communities can help prevent childhood abuse and promote child well-being.

Learn more at https://www.childwelfare.gov/topics/preventing/preventionmonth/

Featured Resource: Connecticut Clearing House

Submitted by Eileen M. Russo, MA, LADC

When I mention the CT Clearinghouse to someone, I usually hear one of two responses: 1. "Oh I love the Clearinghouse!" or, 2. "What is the Clearinghouse?"

To answer the latter of the two responses, the CT Clearinghouse describes itself as Connecticut's library and resource center for information and materials on wellness, drugs, alcohol, and mental health topics. The Clearinghouse operates in three distinct ways. One, is as a traditional library where you may borrow books, DVDs and treatment curricula ($10.00 annual membership fee). The easiest way to find out what is available for borrowing is to go to their website (www.ctclearinghouse.org) and click on "search our library". When I typed in trauma, 280 items popped up.

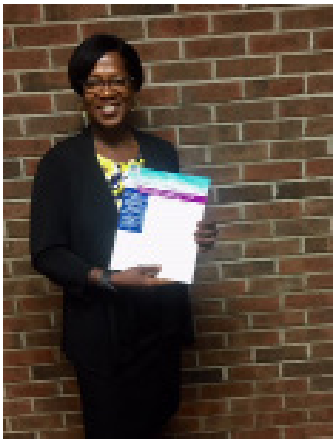
The second method of operation is to provide free online resources. For example, April is Sexual Assault Awareness Month; by clicking on "Topics A-Z" and scrolling to Sexual Violence and Exploitation there are several types of printable fact sheets on this topic. "Topics A-Z" also includes a variety of additional resources including related links, research and statistics, screening tools, and self-help groups, many of which are offered in other languages (e.g. Spanish, Urdu, Arabic and many more).

The third method of operation is simply being helpful. If you are having a wellness event, recovery activity or are highlighting a prevention/awareness month, the staff at the CT Clearinghouse will help you identify relevant posters, pamphlets, fact sheets and other resources.

Clearinghouse Contact information: 334 Farmington Avenue
Plainville, CT 06062

Toll-Free Phone: 800.232.4424
Local Phone: 860.793.9791
Fax: 860.793.9813

Who's Been Reading Trauma Matters?



Pictured at left, DMHAS Commissioner Miriam E. Delphin-Rittmon, PhD.

Dr. Delphin-Rittmon attended the Opioid Use Disorders Prevention and Recovery Conference in July of 2017 at CT Hospital Association.

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www.womensconsortium.org

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