Invisible Injuries: The Epidemic of Misdiagnosed and Untreated Brain Trauma in Women Who Survive Intimate Partner Violence

Presented by Penijean Gracefire, LMHC, BCN, qEEG-D

Intimate partner violence is a pervasive and global health crisis which can often feel overwhelming to address from the perspective of clinical care. Examining it through the lens of traumatic brain injury allows for a more focused discussion that still includes the complex intersections of mental health, neuroscience, social systems, and relationship dynamics. In an article published this summer in the Journal of Women's Health, researchers observed that the front line service providers to individuals impacted by intimate partner violence demonstrated insufficient ability to recognize the signs of traumatic brain injury in battered women and provide effective support (Haag, 2019). Another article in Family Community Health (St. Ivany, 2016) states that a review of available literature indicated 60% to 92% of abused women have an intimate partner violence correlated traumatic brain injury. The Professional Counselor Journal states is estimated that as many as 23 million women in America are currently living with brain injuries incurred from domestic violence (Smith, 2019). The Journal of Neurotrauma indicates that 70% percent of people seen in the emergency room for this type of abuse are never identified as survivors of intimate partner violence (Zieman, 2017), and further states that out of the people they interviewed, 88% reported more than one injury, 81% reported a history of loss of consciousness associated with their injuries, 85% had a history of abuse in adulthood, 22% had experienced abuse in both childhood and adulthood, and 60% of the patients abused as children went on to be abused as adults. Only 21% sought medical assistance at the time of injury. Fear, social conditioning and shame around domestic violence and abuse impact the willingness of survivors to speak up about how they acquired their injuries, but one of the more shocking revelations unearthed in the interviews was how often nobody asked them specifically about a history of intimate partner violence (Zieman, 2017). Clinicians are often uncomfortable with the subject matter, do not feel adequately prepared or trained to handle a situation in which their client may be experiencing physical abuse from a partner, may not have the knowledge to recognize the signs of possible head injury, or do not know the questions to ask to rule it out. This session will discuss clinical strategies to improve provider competency in identifying and addressing traumatic brain injury in clients with histories of domestic violence, complex trauma and multiple mental health concerns. PLEASE NOTE: Breakout spans two sessions (3:00 - 4:30pm and 5:00 - 7:00pm) - must attend both sessions in order to receive full 3.5 CE credit.
Thursday, June 25, 2020

11:00 AM – 4:15 PM 2 Part Session

Geriatric Track | Neuroscience Track

Getting up to Speed to Work Effectively with Senior Adults with Mental Health and Substance Use Disorders

Presented by James J. Messina, Ph.D.

After attending this workshop the attendee will gain and an awareness and knowledge of the needs of seniors and the skills needed in addressing their various needs such as: 1). Clinical Assessment and Treatment Planning; 2). Evidence Based Practices for treating Seniors with Mental Health Disorders; 3). Motivational Interviewing with Seniors; 4). Treating Seniors affected by the Opioid Heroin and Fentynal Epidemic; 5). Treating Seniors with Alcohol and Substance Use Disorders; 6). Preventing and intervening in Senior’s suicides; 7). Collaborative Integrated Behavioral Health Services for Seniors; 8). Neuroscience behind working with Seniors; 9). Mindfulness Based Stress Reduction use with Seniors; 10). Assisting Seniors dealing with handling loss, grief and death and 11). Addressing the Spiritual Needs of Elderly. PLEASE NOTE: This breakout spans two sessions (11:00am - 12:00pm and 3:00pm - 4:15pm). You must attend both sessions to receive full 2.25 CE credit.

OR

3:00 – 4:15 PM Breakout Session Number 2

Neuroscience Track

AMHCA Neuroscience Taskforce Update: Towards a Training Model for Neuroscience Integration

Presented by Thomas A. Field, PhD, LMHC, NCC, CCMHC, ACS

The AMHCA Neuroscience Taskforce was formed in 2018 to develop training standards pertinent to the new AMHCA Biological Basis of Behavior Standards. The Taskforce’s charge for the second year was to develop a model that outlined competencies required for different stages of training. In this presentation, the AMHCA Neuroscience Taskforce will present their training model for integrating neuroscience into counseling practice. This training model contains stages of training associated with entry-level and advanced competence. Participants will have the opportunity to self-evaluate their own competence in providing neuroscience-informed counseling.
Neuroeducation: Practical Translations of Neuroscience in Clinical Work
Presented by Raissa Miller, LPC and Eric Beeson, LPC, NCC, ACS, CRC

Mental health counselors are expected to use interventions informed by current research and best practice guidelines. Principles of neuroscience are increasingly informing best practices and are now included as components of foundational knowledge. For example, the AMHCA Standards for the Practice of Clinical Mental Health Counseling (2018) identify the necessary knowledge and skills for neuroscience-informed practice. One type of neuroscience-informed intervention is neuroeducation, a didactic or experiential intervention that aims to reduce client distress and improve client outcome by helping clients understand and influence the neurobiological processes underlying mental functioning (Miller, 2016). Neuroeducation is grounded in individuals’ here-and-now experience and promotes common factors of change, such as the therapeutic alliance, expectancy, and goal consensus. Although research on the effects of neuroeducation is just emerging (e.g., Louw, Zimney, Puenteédura, & Diener, 2017), practitioners have anecdotally reported many positive uses and outcomes (Badenoch, 2018; Fishbane, 2013; Miller & Barrio Minton, 2016). The most frequently cited benefits include increased empathy and compassion for self and others, decreased blame and shame, greater client empowerment and hope for change, and normalization and validation of experiences. Neuroeducation is much more than providing a reductionist explanation of symptoms; it is about exploring relevant neurobiological principles in a way that honors complexity, individuality, and context. When delivered within a grounded theoretical framework, neuroeducation can serve to enhance the overall therapeutic process. This presentation will focus on introducing attendees to the principles and process of neuroeducation. Participants will come away with a clear definition of neuroeducation and guidelines for implementation. Participants will also be able to observe and participate in two neuroeducation demonstrations.

Building Approach Motivation: Enhancing Wanting, Liking and Reward Learning
Presented by Gary G. Gintner, Ph.D., LPC-S, NCC

The brain has two major motivation systems with associated neural substrates: an approach motivation system designed to seek out reward and linked to positive emotions and an avoidance-motivation system aimed at responding to danger and associated with negative emotions. A range of disorders including anxiety disorders, depression, substance use disorders, schizophrenia and bipolar disorder show dysregulation in both of these systems which results in high levels of negative affect as well as dysregulated approach motivation (e.g., anhedonia, mania and substance use). While our current treatments do a good job of addressing negative emotions and avoidant coping, these treatments show minimal impact.
upon improving positive emotions and indices of approach motivation. This may be why treatment effects show poor durability over time. Guided by affective neuroscience, several treatment protocols have been tested that target components of approach motivation such as reward seeking (wanting), reward enjoyment (liking), and reward learning. The program reviews these treatments and discusses cognitive, behavioral and experiential techniques for cultivating reward sensitivity, enjoyment and engagement in rewarding experiences. Case examples are used to illustrate applications with clinical populations.