Trauma Track
(All times are in Eastern time)

Wednesday, June 24, 2020

2:00 – 6:00 PM 2 Part Session
Trauma Track | Neuroscience Track
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 4:00 - 6:00pm) - must attend both sessions in order to receive full 3.5 CE credit.
5:00 – 7:00 PM Breakout Session 2
Child & Adolescent Track | Trauma Track

13 Reason Why: A Mental Health Perspective on the Glamorization of Suicide
Presented by Sergio Washington, MS and Don Tranhan, PhD, LPC, ACS, NCC and Felicia Pressley, PhD, LPC-S

13 Reasons Why is an international bestseller and Netflix sensation. The series revolves around 17-year-old Hannah Baker, who takes her own life and leaves behind audio recordings for 13 people who she says in some way were part of why she killed herself. Each tape recounts painful events in which one or more of the 13 individuals played a role. Information about the epidemiology of such behavior is important for policy-making and prevention. Suicide is a complex phenomenon, thus, the prevention of it needs to be tailored accordingly. Prevention can occur on both the individual and societal level, with the most effective strategies being a combination of efforts. The session will examine the glorification depicted in the art, draw together key evidence, resources and group discussions as an opportunity to provide feedback on the resources communities need to support their youth.

Thursday, June 25, 2020

11:00 AM – 12:00 PM Breakout Session 1
Trauma Track

Are You Prepared For When a Disaster Hits Your Community?
Presented by Robert W. Schmidt, MS

Up to 32% of victims will suffer from Acute Stress Disorder after a disaster and approximately half will end up with PTSD. With the rise of destructive weather due to climate change, mass shootings, and acts of terrorism, no community is immune to these disasters. When a community is prepared for a disaster they can immediately and more effectively serve the mental health needs of the victims. Mental Health Counselors played a significant role in the healing of the communities after disasters. Counselors can become the leaders in their communities by creating pro-active trauma-informed collaborative groups. The presenter is a Licensed Professional Counselor in private practice in Sandy Hook, Connecticut and played an active role attending to the mental health needs in Newtown. He learned a great deal about the more effective brain-based trauma-specific treatments and will demonstrate them to the participants. All participants will also receive a “Roadmap” that will list all the things that can be done to prepare a community for a disaster.
Child & Adolescent Track | Trauma Track

Multisensory Trauma-Focused Interventions for Elementary School Children with Developmental Disabilities

*Presented by Vanessa B. Teixeira, Ed.D*

Mental health counselors often lack the necessary knowledge and evidence-based training when working with children who have experienced multiple levels of childhood trauma. Trauma-Focused Cognitive Behavior Therapy (TF-CBT) is an evidence-based counseling model widely utilized by mental health counselors when working with children, adolescents and families who have experienced trauma (Cary & McMillen, 2012). This short-term, therapeutic treatment focuses on building healthy coping skills, constructing a trauma narrative, and incorporating substantial parental involvement in the counseling process. Current research suggests that TF-CBT techniques significantly improve trauma symptoms experienced by children and adolescents after being exposed to trauma or significant life stressors (Jensen, Holt, & Ormhaug, 2017). Many mental health counselors are not specifically trained to work with trauma and many do not feel comfortable working with young children presenting with special needs or developmental disabilities such as Autism Spectrum Disorder (ASD), Down Syndrome, Intellectual Disabilities (ID) and Learning Disabilities (Cohen, Mannarino & Deblinger, 2012). This presentation focuses on the importance, use and application of multisensory TF-CBT clinical interventions mental health counselors can use with elementary school children who may present with mild to moderate developmental disabilities. Multisensory counseling interventions can include auditory, visual, tactile, and kinesthetic activities that keep children interested and focused throughout the counseling session (Kahveci, 2016). These types of activities, which can be used in both the school and home environment, are essential to use with children who may struggle with attention, focus, learning, emotional dysregulation, communication difficulties, and various levels of cognitive deficits. An important part of TF-CBT includes involving parents and teachers who may facilitate the therapy process and further help children with any trauma-related symptoms they may be experiencing at home and school. This presentation will also highlight effective ways in which mental health counselors can work collaboratively with parents and teachers to reduce trauma symptoms in children with developmental delays and quickly improve mental health functioning and pro-social behaviors.

3:00 – 4:15 PM Breakout Session 2

Trauma Track | Integration Track

The Impact of a Trauma-Informed Therapeutic Relationship in Reducing Symptoms related to ACEs

*Presented by Vanessa Snyder, PhD, LPC, LMFT and Hannah Boos, BS and William Goodwin, BS*

Kaiser Permanente’s 1998 Adverse Childhood Experiences (ACE) Study, the largest study of its kind, produced shocking results that continue to change the landscape of understanding childhood traumatic experiences as well as treatment for somatic and mental
health problems in adulthood (Herzog & Schmal, 2018; Felitti et. al, 1998). However, according to one of the original researchers in this study, there has been a slow move from the biomedical model to a biopsychosocial approach to treatment. In an effort to create a trauma-informed clinical mental health training program, Richmont Graduate University has incorporated an integration of holistic, trauma-informed education and training, a clinical foundation in the Interpersonal Process and therapeutic alliance, as well as a steady increase in trauma-informed supervision to address the clinical needs of those in treatment with a history of childhood trauma. Using the ACE questionnaire along with the Clinical Outcomes in Routine Evaluation (CORE) assessment, Richmont's trauma-informed counseling centers have measured levels of ACEs along with pre and post-test measures of subjective categories for the following: current risk; negative symptoms (depression, anxiety, trauma and somatic experiences); subjective well-being, and functioning (general and relationship). The results of this study will be examined to inform clinicians and educators on an effective treatment modality for clients presenting with problems associated with early adverse childhood experiences.

OR

Trauma Track
The Neurobiology of Trauma and Its Application to Successful Treatment
Presented by Judith A. Swack, Ph.D. and Wendy Rawlings, MS LMHC

Every therapist has known that moment with a client when they realize they just don't know what to do or say to help them move past their trauma. Something is missing from their repertoire of responses. This class seeks to furnish that missing piece. Because trauma is a universal experience, therapists need to understand how trauma imprints in the body and how it is structured so they can identify the causes and treat it effectively. Sometimes, however, the origin of the trauma is tough to find. Symptoms recur when the root cause is not found or goes untreated. If therapists don't understand the neurobiological underpinnings of trauma in the body, they may miss important clues and create false assumptions. In this class, the presenters will describe the neurophysiology of trauma and review the evidence-based research on the use of Energy Psychology techniques for treating trauma by Van der Kolk, Swack, Seigel, Porges, Church, and Feinstein (to name a few). Dr. Swack will then share her published research on the structure of trauma and teach participants a rapid and effective process for treating it. Through observation, testing and retesting, Dr. Swack has found that the first layer of trauma contains shock/fear, anger, sadness, and pain. The second layer of trauma is composed of core beliefs including issues of shame, blame, and guilt and feelings of powerlessness. The next layer requires processing feelings of grief and emptiness in the case of loss trauma or pollution in the case of violence. The last layer is the anticipatory anxiety caused by the trauma. Dr. Swack has created a protocol to accurately find and treat the layers of trauma using the body's own resources and systems and Meridian Tapping techniques such as Emotional Freedom Technique (EFT). Both Dr. Swack and Ms. Rawlings will describe how they have used this
method for treating trauma in adults, adolescents and children. It is effective in treating secondary trauma, so therapists can use this protocol for their own self-care. This method is a must for any therapist's toolbox and participants will be able to use it with their clients Monday morning.

5:00 – 6:30 PM Breakout Session 3
Trauma Track | Specialized Clinical Assessment
How to Ace Your Case Conceptualization with ACES: Transforming Your Practice With Trauma Informed Conceptualizations
Presented by Russell MacKay, CMHC, NCC, SSW and Jessica Saxton, LCMHC, NCC
Clinicians are often faced with complex cases and one of the ways that case conceptualization helps clinicians is to make decisions in these complex cases (Persons, 2013). While there are various models, one thing to note in all of these models, there is no specific way to do conceptualization and it seems that it is just left to the clinician to insert their conceptualization into the final assessment of the client (Eells, 2013). The job of a clinician is not easy. They must take the whole life-history of a client, condense it into meaningful themes and patterns, build rapport, create a treatment plan including goals, choose the best evidenced based strategies and interventions, keep in mind best practices within a multicultural framework, and many times do all of this within the first few sessions, as insurance companies, internal company policies, and funding sources all have deadlines for the diagnosis and treatment planning (Ridley, Jeffrey, & Roberson III, 2017). ACES can delay the diagnosis of certain mental health disorders (Berg, Acharya, Shiu, & Msall, 2018). This can lead to less optimal outcomes for these clients. Also, when conceptualizing cases it is important to remember that individuals who have been through Adverse Childhood Experiences may impact their ability to have conscious self-awareness which can lead to problems with traditional therapy (Zyromski, Dollarhide, Aras, Geiger, Oehrtman, & Clarke, 2018). Another area that is sometimes a struggle for clinicians is understanding the implications of adversity and the impact of trauma on cognitive functioning and seeing the client through a conceptualization model that integrates neuroscience can be helpful. Using a comprehensive approach that includes biological, psychological, social, cultural, and spiritual aspects of case conceptualization clinicians can be more trauma informed in their treatment and conceptualizations.

Friday, June 26, 2020

11:00 AM – 12:00 PM Breakout Session 1
Trauma Track | Integration Track
Sleeping with the Enemy: Identifying and Treating Trauma-Related Sleep Problems
Presented by David Engstrom, Ph.D., ABPP, DMHCS
Disturbed sleep, especially insomnia, is a major contributing factor to physical and mental
illness. Sleep deprivation results in numerous costs to the individual and society. The components of "normal" sleep will be detailed, as well as definitions of insomnia and statistics regarding disturbed sleep in the US. The relationship between stress and insomnia will be discussed and connected to how overproduction of cortisol can disturb sleep, due to its physiologically arousing properties. It is reported that between 70-91% of clients with PTSD experience chronic insomnia, primarily due to their state of chronic arousal. Research has indicated that insomnia often arises in clients with a history of childhood maltreatment and trauma. Childhood maltreatment has been associated with elevated cortisol levels. One study shows that frequent experience of physical and/or emotional abuse led to clinically relevant sleep pathology over 200% higher than in those who reported no abuse. The prevalence of childhood abuse will be described and current assessment techniques will be explained, including the ACEs evaluation. Several sleep assessment tools will be provided to attendees including a basic Sleep Log or diary for clients to self-report their sleep patterns and the Pittsburgh Sleep Quality Index for more intensive evaluation of sleep problems. Ten basic rules of sleep hygiene will be outlined and reviewed in detail, with guidance for clients. The landmark "three P's" of treatment of insomnia will be presented for evaluation: Predisposing factors, Precipitating events and Perpetuating mechanisms. The question of whether to treat the insomnia directly or the traumatic experiences first will be discussed, with emphasis on the possibility that both can be treated simultaneously. Finally, several therapeutic techniques will be described and applied, including Cognitive Behavior Therapy for Insomnia (CBT-I), mindfulness-based treatment for insomnia, Trauma-Focused CBT (TF-CBT) and Dialectical Behavior Therapy for posttraumatic stress disorder related to childhood sexual abuse.

3:00 – 6:30 PM 2 Part Session
Trauma Track | Couples & Family Track
Trauma and Eating Disorders: Interventions Utilizing EMDR and Art Therapy Techniques
Presented by Marie Rothman, LPC-S
The presentation titled Trauma and Eating Disorders: Interventions Utilizing EMDR and Art Therapy Techniques, will explore the role that trauma plays in the formation and continuation of Eating Disorders, will provide an outline of the major types of eating disorders (as well as other DSM-V indicated Eating Disorders), will instruct clinicians on how they can assess for each disorder with clients, and will provide knowledge and skills required for clinicians to implement EMDR and Art Therapy technique interventions. The application of art therapy techniques and the extended resourcing in EMDR interventions enables the art created by clients to act as an intervention for body image issues by installing their positive beliefs portrayed in their artwork. Moreover, in managing negative beliefs, the clinician can desensitize the negative beliefs with another creative art technique called Storytelling. The client can draw a series of pictures surrounding the onset of the eating disorder with the emotional experiences and negative beliefs associated with that period of time to be desensitized and reprocessed through the EMDR model of therapy intervention. This presentation will show how this work can be used to assist in treating individuals, families, and couples. Included in this presentation is a practicum section for the
clinicians/participants to acquire and strengthen skills learned that can be used when working with their clients who have experienced trauma and resulting Eating Disorders or body image issues. PLEASE NOTE: This breakout spans two sessions (3:00pm - 4:15pm and 5:00pm - 6:30pm). You must attend both sessions to receive full 2.75 CE credit.

OR

5:00 – 6:30 PM Breakout Session 3
Diversity Track | Trauma Track
"Why They Don't Come Back": Understanding and Challenging Barriers to Treatment When Counseling Minority Clients
Presented by Portia X. Allie-Turco, MS., LMHC, NCC

Studies indicate that fewer than half of all racial minority adults in the U.S. who experience a mental health disorder receive treatment. Within those racial minority individuals who do seek treatment between 50-60% terminate therapy after the first session even though the rate of need for services is higher. Historical, cultural and environmental factors that create barriers include: Inability to recognize and accept mental health problems; reluctance to discuss psychological distress; social stigma against mental illness; the relationship between the client and mental health provider; insensitivity about historical trauma; lack of clinical skills or awareness of dominant cultural messages, and implicit bias towards minority clients. This presentation will focus on historical, political and cultural barriers impacting access to mental health services for minority clients with a deeper exploration of how traditional counseling theories and concepts in mental health may be culturally incongruent and may promote early attrition by minorities. Mental health providers will evaluate their competencies and learn evidence-based strategies to deliver culturally sensitive care.