# TRAUMA MATTERS

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# They See What They Get: How Early Violence Exposure Shapes Perception and Behavior

It's fascinating to be a father of two daughters, 4 and 5 years old, who experience the world the way only young children can—where so much is new, and what they learn today shapes how they experience tomorrow. As such, my wife and I try hard to promote opportunities for new learning while delaying exposure to realities that threaten their innocence, such as the violence that too often crowds our adult news feeds in this age of instant information sharing. I shudder when they come close to realizing its existence. Our children are relatively naïve to violence. In their environment, they can actively and securely explore their gradually expanding world and master developmental competencies, such as regulating emotions, understanding right from wrong, and formulating a concept of self. These early accomplishments lay the foundation for attaining skills and knowledge at later stages of development.

This isn't the case for a sizable number of young children for whom exploration and mastery of skills is overshadowed by a need to anticipate, prevent, or protect oneself or a caregiver against actual or potential danger. Children exposed to family violence are developing in environments where safety is unpredictable, violence is frequent, and the very person they are most dependent on for security and nurturance is often unavailable or actually causing them harm. These children may develop an enhanced capacity to rapidly and efficiently detect and respond to threat, which may serve an adaptive role in these situations (LeDoux, 2000; McEwen, 2007). This capacity, however, may come at a high price, with compromised attainment of developmental competencies and difficulty resigning from these survival tendencies in more secure environments more suitable for learning and healthy development.

Consider Sasha, a 5-year-old girl who has had repeated exposure to physical conflict between her mother and her mother's partner. After the most recent assault, which landed Sasha's mother in the hospital, they fled the perpetrator and sought refuge in a domestic violence shelter. In an intake interview, Sasha reported fears that Mom's partner would kill her and told about times he threatened to run her over with the car and a recent incident when he held a gun to her head. Other times he threatened to make it so that Mom never saw Sasha again. Sasha reported an intense fear that her mom's partner would find them—especially given that they were on the first floor with a window facing the street. Sasha's mother described Sasha as her "little guardian angel" who is constantly looking out for her. Mom's biggest wish was for Sasha to have a chance to be a kid and stop worrying so much: *"The problem is that Sasha sees danger even when it's no longer there … sometimes no matter how hard I try, I can't bring her out of it … she's stuck."*

A growing body of research supports the link between violence exposure and alterations in the detection of and degree of attention allocated to perceived threat. These abnormalities in threat responding may appear as early as half a second from the onset of a threat cue. Studies of event-related brain potentials, measured using scalp electrodes and reflecting brain activity in response to a stimulus, show evidence of greater indicators of extremely early, preconscious attention to threat-related cues (e.g., angry faces, conflict) relative to neutral ones (Grasso & Simons, 2012; Olofsson, Nordin, Sequeira, & Polich, 2008), with enhanced detection for those affected by trauma exposure (Karl, Malta, & Maercker, 2006; Shackman, Shackman, & Pollak, 2007). Thus, for trauma-exposed children, preconscious detection of threat, whether actual or perceived, may happen more readily—even after they are no longer living in a dangerous environment.

Attentional processing that occurs later (e.g., > 1 second) and that involves more cognitive control mechanisms has been measured as differences in reaction time to threat versus non-threat cues during a computer task. Several of these studies have linked both attention bias *toward* threat and *away from* threat to anxiety and trauma-related impairment, mainly in adults and older children (e.g., Bar-Haim et al., 2010; Sipos, Bar-Haim, Abend, Adler, & Bliese, 2014). Presumably, individuals with a bias toward threat may become *stuck* or fixated on threat cues, which may compromise their ability to attend to other stimuli and tasks; intrusive re-experiencing symptoms may be associated with this tendency. A bias away from threat may reflect individuals who are quick to perceive threat but then divert attention away in an effort to avoid it, perhaps without fully processing it; symptoms of avoidance and numbing may be associated with this tendency. Although there is little work of this nature in young children, in a study led by colleagues Drs. Margaret Briggs-Gowan and Laurie Wakschlag, we have demonstrated associations between attention bias to threat and concurrent and developing trauma-related symptoms in preschool age children (Briggs-Gowan et al., in press; Briggs-Gowan et al., 2015; Mian, Carter, Pine, Wakschlag, & Briggs-Gowan, 2015).

Once a person detects threat and processes it as imminent, the fight/flight stress response ensues and is revealed by acute changes in the autonomic nervous system, which mobilizes the body for action. Numerous studies have associated trauma-related impairment with increased autonomic reactivity (e.g., heart rate and skin conductance responses) to threat cues in adults (e.g., McTeague et al., 2010; Pole, 2007), with fewer studies in children (e.g., Grasso & Simons, 2012; Scheeringa, Zeanah, Myers, & Putnam, 2004). Indeed, several of the symptoms that characterize the arousal and reactivity cluster (Criterion E) of the *DSM-5* posttraumatic stress disorder diagnosis directly refer to these changes. Interestingly, there is some evidence that autonomic indicators measured prior to or soon after trauma exposure predict the development of trauma-related symptoms (Bryant, Salmon, Sinclair, Psychol, & Davidson, 2007; Pineles et al., 2013). Another way of quantifying threat reactivity is though observational coding of behavior. In the aforementioned study, we have observed fear/anxious behavior of young children in stress-inducing tasks in which they are exposed to stimuli such as a remote-controlled spider and a mystery slime jar. For children exposed to family violence, those exhibiting heightened fear-anxious behaviors were more likely to have clinically significant trauma-related symptoms concurrently and over time (Briggs-Gowan, Mian, Carter, & Wakschlag, 2011; Mian et al., 2015).

Another question has to do with how chronic or multiplicative exposure to violence and trauma imposes cumulative risk for impairment in which there seems to be a dose-response relationship between exposure and a host of physical and psychological problems across the lifespan. This notion emerged from the prominent Adverse Childhood Experiences Study (Dube, Felitti, Dong, Giles, & Anda, 2003) and has been further explored by the National Survey of Children's Exposure to Violence (Finkelhor, Ormrod, & Turner, 2009) and other studies of diverse populations (e.g., Ford, Grasso, Hawke, & Chapman, 2013; Grasso et al., 2013). Colleagues and I have recently shown that a small but not unsubstantial portion of young children have been exposed to multiple types of adversities, and that this pattern of exposure predicts trauma-related symptoms and behavioral reactivity in observational paradigms (Grasso, Briggs-Gowan, Henry, & Wakschlag, 2016) and can serve as a gateway to subsequent exposure to violence and trauma and to impairment in middle childhood and adolescence (Grasso, Dierkhising, Branson, Ford, & Lee, 2015). Children such as Sasha who grow up in homes with family violence endure direct and indirect forms of violence, as well as other co-occurring forms of adversity and maltreatment. What is the relationship

between this cumulative exposure and the development of the stress response system, and how might this play a role in developmental psychopathology?

A final and important point is that not all children who are exposed to trauma and violence go on to develop trauma-related impairment. Factors exist that buffer the impact of trauma and serve protective roles. Can we harness these factors to promote resilience in children at risk for exposure? For young children, a key protective factor involves a nurturing caregiver. Early responsive parenting is critical in helping young children regulate emotions and behavior in response to stress and perceived threat. For my daughters, our ability to model and teach healthy ways of responding to stress may help them to respond and adapt more effectively to subsequent stressful events—even trauma—where we know that peritraumatic responses (e.g., lack of perceived control) during or immediately following trauma can predict the development of impairment (Bovin & Marx, 2011). Recent studies support the protective role of positive parenting behaviors in families with intimate partner violence (Barnett & Scaramella, 2015; Graham-Bermann, Gruber, Howell, & Girz, 2009). Our study demonstrated that observed indicators of responsive parenting predicted lower trauma-related symptoms in children across 6 months. Thus, for Sasha, her mother's ability to scaffold her emotional experiences and model effective emotion regulation strategies may play a substantial role in Sasha's ability to recover from her experiences. The best thing here is that parenting is modifiable, meaning that we can develop interventions for increasing parenting behaviors that promote resiliency.

In conclusion, research focusing on early pathways of trauma-related impairment and the role of so-called intermediate phenotypes, biobehavioral mechanisms that may explain how symptoms manifest, is critical to moving the field forward toward building more effective ways of interrupting these pathways. Specifically, focusing on threat reactivity as an intermediate phenotype and the role of modifiable features of the family environment that may buffer risk may prove to be a promising step in this direction.

**Submitted by Damion J. Grasso, PhD**

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# Understanding How Food Matters

As administrators and clinicians, we strive to provide trauma-informed, gender-responsive programming to the people whom we serve. Infusing this perspective into the design of our agencies and clinical services can improve organizational climate, promote client outcomes, and facilitate healing in the world around us.

Food is an important factor in this equation that is often overlooked. People across time and place use food to construct identity and relationships, including negotiations of gender and power. Do food systems at your agency support its overall mission by promoting dignity and health, or do they undermine clinical services by humiliating clients and perpetuating self-harm?

A new publication, *Food Systems in Correctional Settings*, from the **World Health Organization's Regional Office for Europe** encourages us to survey how, where, and when food is used within our agencies. While this document examines food in correctional facilities, it provides a framework for understanding food in myriad settings. The publication begins with a summary of existing research about the impact of food on the physical and psycho-social health of people who are incarcerated. It then presents a case study from Denmark that highlights the creative ways correctional systems can use food to improve outcomes. Finally, **7 Action Steps** are suggested to lead agencies through a process of understanding and improving client and staff interactions with food. In short, this brief report makes the case that food matters and offers specific suggestions to ensure that food systems support our efforts to provide trauma-informed, gender-responsive care.

To read the full report, go to:
http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications and click on the *Food Systems in Correctional Settings* link.

**Submitted by Amy B. Smoyer, PhD,**
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# Ask the Experts:
# A Conversation with Jim Knipe, PhD

**By Cheryl Kenn, LCSW**

Jim Knipe, PhD, has been a licensed psychologist in private practice in Colorado since 1976 and has been using Eye Movement Desensitization Reprocessing (EMDR) since 1992. He is an EMDR-Humanitarian Assistance Program (HAP) Trainer and an EMDRIA Approved Consultant and Instructor, and was designated a Master Clinician by EMDRIA in 2007. He was a keynote speaker at the 2010 EMDRIA Conference and 2015 EMDR Canada Conference, and he was an invited guest speaker at the 2006 and 2007 EMDRIA Annual Conferences, the 2006, 2008, and 2012 EMDR-Europe Annual Conferences, the 2010 EMDR Asia Conference, and national EMDR conferences in Denmark, Germany, Scotland, Italy, Belgium, Sweden, Spain, the Netherlands, Turkey, and Japan. He has been involved with the EMDR-HAP, serving on the board of directors and as research and training director, and has also been part of HAP programs in Oklahoma City, Turkey, New York (following 9/11), the Palestinian Territories, Sri Lanka, and Indonesia

In addition, he is a co-author of published outcome research documenting the effects of EMDR with survivors of 9/11 and with those traumatized by the 1999 Marmara earthquake in Turkey. Dr. Knipe has contributed chapters to *EMDR Casebook* (2002), *EMDR Solutions, Volumes I and II* (2005, 2009), *Healing the Heart of Trauma and Dissociation* (2007), *EMDR Scripted Protocols: Special Populations* (2009), and *EMDR and Dissociation* (2012). His book, *EMDR Toolbox: Theory and Treatment for Complex PTSD and Dissociation*, was published in August 2014, and he is a co-author (with Dolores Mosquera) of an article in the Winter 2015 issue of the *Journal of EMDR Practice and Research* entitled "Understanding and Treating Narcissism With EMDR Therapy."

### How did you become a trauma therapist?

Actually, I came to focus on trauma by an indirect route. My graduate program in the '70s was heavily cognitive behavioral therapy CBT, which was avant-garde at the time, and the emphasis was on conceptualizing every existing diagnosis as originating in dysfunctional life experience and faulty learning. Treatment then involved replacing faulty learning with new skills. I carried that model into my first job, with a crisis center and partial hospitalization program in the community mental health center in Colorado Springs. I quickly learned that this "skills" model left out feelings—the client's emotional pain—but I continued to work with at-risk clients for several years. I tended to use cognitive restructuring and prolonged exposure (PE) but found that the PE approach of "staying with the feelings, staying with the trauma flashbacks" was too difficult for many people. New cognitive understandings didn't always solve the problem. One woman said, "I understand now why I am so anxious, but I'm still anxious!" When I took the EMDR training, it was an answer to that dilemma. EMDR—for most trauma memories—truly resolves the feelings and often, as a bonus, adds to cognitive understanding. It fit like a glove into my arsenal of therapy tools to work with more complex clients.

I think that the concept of psychologically traumatic memory is evolving. A diagnosis of Post-Traumatic Stress Disorder (PTSD) requires, first, exposure to actual or threatened death, serious injury, or sexual violation, and then re-experiencing of that life threat, but this definition is too limited. In 2005, Mol and colleagues (2005) found that the most distressing (and, by implication, impactful) memories for most clients were not life-threatening events. Maybe we need a new word for it. If a child is told, for example, by a parent, "We were happy until you were born," or something like that, that is not a life-threatening event, but it is something that is likely to severely alter that child's developing sense of self. The problems of many adult clients originate with that type of experience. I think it is useful, in talking to clients, to shift the wording from "traumatic memory" to "trauma *reliving*." This shift is often clarifying and says to the client, "That explains why you, here in my safe office, when you know I like and respect you, still, nevertheless, have feelings of terror when you think of what happened—when you barely escaped from the burning house or when your father hurt you badly when you were 7." The client can easily recognize that he or she is still having those feelings or those flashing pictures even though there is an objective realization of present safety. The client is experiencing a reliving, and it can occur to a small extent or to an overwhelming extent. That shift in wording fits better, I think, with what the client is experiencing.

### How is this concept of reliving applied in your approach?

The shift in wording resonates with what is in the client's head, and also, when clients come into therapy, they don't just bring these post-traumatic relivings. They also bring the ways they've learned in their lives to protect themselves from being overwhelmed by those relivings—that is, their defenses. That's a slightly different definition from the psychoanalytic definition of defense, i.e. mental actions, often unconscious, which function to prevent emergence of impulses of various kinds. I find it useful to talk about defense as the ways a person has learned to prevent the emergence into consciousness of what is basically post-traumatic affect. Within this definition there are many types of defenses, for example, avoidance, addictions, idealization, and self-shaming. In addition to relivings and defense, there is the issue of separate personality parts, which may or may not have conscious access to each other and which may have very different agendas for life and for therapy. There are clinical procedures in which focused sets of bilateral stimulation (e.g., eye movements) can facilitate resolution not only of post-traumatic relivings but also of defenses and the phobic separation between previously dissociated personality parts.

### What are the most significant clinical experiences that now influence your work?

There have been discoveries all along. I had a startlingly positive experience in my initial EMDR training, in the practicum, and that made me realize that there is something to this, and it is something I'm going to want to pursue, explore, and understand. Then, shortly after I began using EMDR in my practice, I had several clients who, in spite of themselves, were trying not to think about, not talk about, some unhappy things that had initially caused their presenting problems. I found that avoidance defenses could be diminished by targeting the positive feelings of relief that go with successful avoidance. Other defenses could be handled in a similar way. Another experience was in finding EMDR-related ways of helping dissociated parts overcome their phobic avoidance of each other and move on then to a healing, integrative conversation—for example, a dialogue between an adult part who does not want to think of the childhood abuse and a child part who is still re-experiencing that abuse. That dialogue couldn't occur previously because that person's adult part was avoiding, avoiding, avoiding.

### Can you discuss what you view as most important in preparation prior to trauma processing?

In Janet's (1907) model, there are many important aspects to Phase 1, preparation, but the most important aspect is helping the client develop the ability to maintain, or return to, awareness of the present, that is, change mental states from the trauma re-experiencing state to something that feels safer and is more oriented to present reality. Some clients, even some with extensive trauma histories, can keep orientation to the present even while accessing traumatic material. But for others—those vulnerable to dissociative switching—this skill may be lacking initially. The method I use to teach this skill is the Constant Installation of Present Orientation and Safety (CIPOS) method, but there are other ways to do that too. It is also important, as part of preparation, for the client to develop a beginning cognitive understanding of the path therapy will follow to meet his or her goals. And, of course, the empathetic attunement of the therapist helps with all aspects of preparation.

### What advice would you share with trauma therapists?

It is hard to single out one piece of advice. Of course I'd suggest they get some EMDR training, because the research is pretty clear that it is so effective with PTSD. Neurofeedback also appears to have a lot of promise. I'd suggest that a trauma therapist should have a good understanding of a parts model of personality. But I think the most important thing for a trauma therapist is the ability to stay with the client's experience, with accurate attunement and compassion, and without fear of what the client is telling or may tell. The effective trauma therapist really is able to have a model of what it's like to be in the client's head. This is communicated so that the client knows, My therapist gets it; my therapist is on my side. I think that's more important than resourcing. All these elements of preparation are important, but I think that's the most important thing—to be able to simply observe the client in a way that is unafraid and deeply empathetic.

# Featured Resource
# DMHAS Integrative Medicine Activities: Supporting Mind, Body, and Spirit

Connecticut's Statewide Behavioral Health Integrative Medicine Collaborative was established in February of 2016 by Commissioner Delphin-Rittmon of the Department of Mental Health & Addiction Services. The collaborative aims to further the Department's commitment to providing person-centered approaches that are grounded in science and to promote and coordinate statewide integrative medicine activities within Connecticut's behavioral health service system. Members of the collaborative, a group of approximately 50 representatives from mental health and substance use treatment agencies, have an interest in or practice integrative medicine approaches. The group's first task was to identify four primary areas of focus.

**Work groups have been formed to begin addressing each priority area:**

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Research **/** Education and Professional Development **/** Conference Planning **/** Web Page Development

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For more information on the CT Statewide Behavioral Health Integrative Medicine Initiative, contact: Cheryl Stockford at cheryl.stockford@ct.gov; DMHAS Managed Services Division

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