



SPRING/SUMMER 2009

# SIERRA TUCSON PROGRESS

## “Sierra Tucson’s Model for Trauma Treatment” By Bill Coleman, LMSW, TEP

Developing a model of treatment for Trauma requires a great deal of experience and thought. Most of the research has been in Cognitive Behavioral Therapies and focuses on Post-Traumatic Stress Disorders (PTSD), using the current DSM-IV-TR definitions; clinicians report substantial successes with CBT.

Sierra Tucson opened in 1983, developed the Sierra Model®, and has been treating trauma since the late 1980s. Our staff has pioneered and refined the use of experiential and creative arts therapies for the treatment of trauma and many other conditions. The kind of patients we see do not often fit into the standard PTSD definitions; rather, we see patients who more closely conform with the emerging definitions for Complex Post-Traumatic Stress, which emphasizes the loss of sense of self and overwhelming shame. We support the effort to move Traumatic Stress Disorders out of an Anxiety Disorder category and create a new category of Shame Disorder.

Throughout Sierra Tucson’s years of treating trauma and refining our model, we’ve also been a premier substance abuse or chemical dependency (CD) treatment center. Most large treatment centers address the problems of co-occurring disorders or dual diagnoses, and it is widely acknowledged that chemical dependency rarely occurs as a single disorder. We also know that addictions tend to migrate into different behaviors within the same person over time. Many people treated at Sierra Tucson for chemical dependency also have a catalog of other afflictions, such as mood disorders, chronic pain, sexual compulsivity, eating disorders, and underlying complex traumatic stress disorder. The role of the substance abuse counselor has become a lot more complicated.

There is, however, a fundamental dilemma in treating chemical dependency alongside trauma. A patient admitted primarily for chemical dependency must, of necessity, receive addiction treatment. And it must come first. An active addiction will generally negate mood or trauma treatment, as the CD patient always has an escape readily at hand when feelings become overwhelming. There is an exception to this protocol, and that involves the chronic relapser who will never get sober until the underlying problems are addressed. Such patients usually require long-term extended residential care of six months or longer.

To address these issues at Sierra Tucson, we have two strategies. First, CD therapists are skilled at introducing some elements of trauma work alongside addiction treatment. Patients are introduced to Eye Movement Desensitization and Reprocessing (EMDR), and they are required to attend Grief and Spirituality groups as well as Psychodrama groups. The CD patient experiences emotional release work, which is not, of itself, trauma resolution. Second, it may be determined to be appropriate for a patient to spend two weeks in CD and then transfer to a Trauma group for four weeks. Since the emphasis in addiction treatment is primarily behavioral, the addicted trauma patient will acquire the fundamentals of getting and staying sober before moving into the deep affect work that is the centerpiece of our trauma model.

The blending of therapeutic approaches becomes less of an issue and almost disappears with “purely” trauma patients. Trauma treatment at Sierra Tucson is essentially deep affect repair work with a solid neurobiological foundation. The primary goals are to reduce shame and restore a sense of a coherent self. The trauma itself is never “fixed.” It is the aftermath, the coping strategies, and the defense mechanisms that we work with. It is important to stress that at Sierra Tucson trauma treatment is not behavioral work. It can be incredibly confusing for the trauma patient to mix up the two: behavioral work and deep affect work. Most trauma patients have little trouble distinguishing their adult dysfunctional behaviors, though that does happen. They come to treatment to get at the deeper, hidden forces that are driving their behaviors. Most trauma patients would, in a heartbeat, change their behaviors if they could. And, herein, lies an ongoing discussion among treatment professionals—the issue of holding a trauma patient accountable for their behavior while in treatment. Certain behaviors must be addressed but, for the most part, holding a trauma patient accountable

*(Continued on page 2)*

<i><b>In this Issue</b></i>	<i><b>Page</b></i>
Model for Trauma Treatment . . . . .	1
Letter from the Executive Director . . . . .	2
Summit for Clinical Excellence . . . . .	3
Meet Nancy Jarrell, M.A., LPC, EAP . . . . .	4



*(Continued from page 1)*

for their behavior while in treatment is like scolding the puppy for throwing up on the carpet when the problem is deep inside its stomach. In trauma treatment, the objective is to express powerful and messy feelings as a means of getting to the deeper problems.

The work involves a very gentle and slow process of first building trust and safety, along with the patients' usually first attempts to express openly what they can remember. Trauma is damaged memory, both declarative and emotional (or implicit and explicit). Trauma victims can remember the facts of their lives but without any affect; or, they are overpowered by affect and cannot connect the feelings with any facts; or both. We are much better at understanding these phenomenon, particularly the neurobiology involved. We now know that the hippocampus, which works closely with the medial prefrontal cortex and is the locus of initial memory processing and retention, has been damaged by traumatic stress. It has shrunk. Though trauma is not the only stress which impairs the hippocampus, I like to think of it as a flash drive that has been pounded by a hammer. Whatever information comes back out is going to be horribly scrambled.

Further, damage to the hippocampus from traumatic stress can not only cause memory problems, it can also impair new learning. Researchers in Complex Post-Traumatic Stress refer to the trauma sufferer as having shifted from a learning brain to a survivor brain. This points to the case for contraindication of behavioral work in trauma. We do not need to add to the stress.

Attached to the hippocampus is a tiny little knob called the amygdala, which acts as a gateway for information processing and for triggering survival responses throughout the brain. It has also been damaged by traumatic stress and has, in fact, increased

in size, further compounding the problem. In consort with the hippocampus, the amygdala, in the trauma sufferer, is prone to constantly trigger a survival response, whether one is appropriate or not. This again informs the case of contraindication of behavior impositions on trauma sufferers while in treatment.

There are many other areas of the brain that are impacted and damaged by traumatic stress. For example, there are disconnects to the Broca's area of the brain, which manages speech production and is involved with organizing hierarchies of behaviors. The upshot is that traumatic stress produces essential survival responses that evolve into dysfunctional behaviors. Treat the behaviors, and you have well-behaved (for a while) people walking around with untreated Complex Post-Traumatic Stress Disorder. Other symptoms will appear.

So how do we treat traumatic stress? The primary tool for healing traumatic stress is now and always has been story-telling. Can it be as simple as that? Ancient peoples instinctively knew this and, at the end of the day, would sit around the fire and tell stories of the day, the family, the hunt, the weather, the generations. Whatever traumatic stress had occurred would be resolved through story-telling. Memory was constantly restored. We moderns are not so lucky. We don't sit around the fire (let alone the dining room table) and tell stories of the day. We have, sadly, handed that essential part of our psychic health to the media, who gives us back the sitcom. We give ourselves no opportunity to heal. We give ourselves no opportunity to feel.

At Sierra Tucson we essentially try to duplicate ancient man and his story-telling. We also add psychopharmacology and many therapies. But first we provide the container, primarily led by the Unit Therapist,

*(Continued on page 3)*

## *Letter from the Executive Director Patricia L. Ryding, Psy.D.*

Dear Friends,

I send you warm greetings from Sierra Tucson. My first six months have been a blur of meetings, greetings, and events. I have managed through it because I believe so passionately in what we do; compassionate care and clinical excellence. This truly is sacred ground.

I am pleased that Nancy Jarrell accepted the position of Clinical Director in April, as she brings a wealth of knowledge and experience to this position. Nancy's direction has helped us to navigate through the bumpy economy and continue to focus on treating people.

Despite the challenging economy, we have been able to develop programming to better serve our patients. We have begun a pre-treatment group to help new patients adjust to treatment. In this group, patients get a clearer understanding of expectations, rules, and the treatment process. This helps minimize patient's confusion and support their adjustment.

We have also opened a new group called "Directions" to support our more fragile psychiatric patients. This group supports

the patient in preparation for the foundational programs. It includes the use of the expressive arts, meditation, experiential work, and some basic DBT skills building. We are also integrating our new therapy dog, "Scout," into the program.

We're excited to have re-instituted trail rides for our Progressions patients and hope to expand into other programs.

In other exciting news, we have successfully rolled out our SPECT services on our campus. It has been an amazing tool to help motivate patients to live a brain-healthy life and give the treatment team a better understanding of individual patients' limits and challenges. Dr. Johnson will be conducting lectures in the future about the use of SPECT in treatment.



I thank you all for your caring support.

Namaste,

Patricia L. Ryding, Psy.D.  
Executive Director

(Continued from page 2)

for the patient to feel safe enough to begin the process of storytelling. Patients tell their stories often and in many ways, such as group introductions, time lines, psychodrama, grief letters, and home work assignments in the Family Program. We also provide tools to help patients recover and repair memory, such as EMDR and Psychodrama. We help them stitch back together the shards of their broken declarative and emotional memories. We also provide another quite new therapy, Somatic Experiencing®. This further complements healing by helping to balance the central nervous system, which has been thrown into chaos by traumatic intrusions. Once all of these processes have begun, the brain and nervous system begin to heal themselves. We now know there is such a thing as neurogenesis, where the brain actually creates new cells. We also know about neuroplasticity, where the brain will begin to create new pathways to compensate for damaged ones. It is something akin to how our cardiovascular system will develop ancillary blood flow to compensate for areas of impaired flow. It is miraculous for a trauma therapist to witness this happening in a patient and to be part of that healing.

Again, trauma treatment at Sierra Tucson is not behavioral. It is deep affect repair work largely concentrated around shame. We use the patients' behavior presented in treatment as a pathway to deeper exploration and understanding of the underlying trauma and coping strategies that emerged and to bring out what I call "trauma disease." In effect, we need the patient to "act out," so the dysfunctional behaviors will come to the surface while in treatment. I call it "getting messy." When trauma treatment is working, it is invariably messy. Of course, there are limits. Behaviors that violate safety and confidentiality cannot be tolerated; nor can sexual acting out.

All that being said, we do not ignore adult dysfunctional behavior. What we do is help the patient connect the dots between a behavior and the underlying coping strategy that is at work. One particularly powerful tool we use is called the "Little Me" diagram of trauma and behavior. The key is to use the term behavior in place of defense mechanism or coping strategy. The exercise is a drawing, a mandala, of the patient's history of childhood trauma, the coping strategies developed, and the resulting adult dysfunctional behaviors. This is done in the final week of treatment, and the results have been universally positive. Patients come away understanding for the first time the full scope of their trauma history and the subsequent behaviors they created. With the brain fully engaged in understanding what has happened, the patient is then ready to move on to change those dysfunctional parts of their lives.

A word about the family. Traumatic stress is embedded within the family system. In treatment, when a patient commits to change, the entire system will be affected. Perpetrators may be close at hand in family work and never held accountable. One family member's

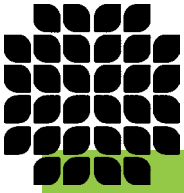
trauma work may trigger another family member to remember themselves as victims. Caregivers may be overcome with guilt and shame. The big question is, when does the patient reveal to the family the full extent of their trauma history? The answer is when it is safe to do so for both the patient and family member. This process must never be rushed to accommodate a preconceived schedule. It must never be done in the form of "leveling feelings" or "confrontation." The degree of shame and guilt on both sides is going to be profound. It must be rooted in the depth of the story, not in the impact of current behaviors. Both sides need substantial therapeutic support.

A word about the "victim." Trauma sufferers are victims. Traumatic stress happened to them. Most trauma sufferers try to displace responsibility for their trauma back onto themselves. It is a perfectly designed childhood strategy. Life is intolerable... I am the center of life... I am responsible. While it is important to help the trauma sufferer eventually realize they do not have to spend the rest of their lives in the victim state, it is more important to correct the original belief that the sufferer is to blame. In early treatment, trauma therapists are on shifting sands when they try to emphasize coming out of the victim role. The one difference occurs in roleplays or psychodrama. Here the victim can begin to practice the role of the non-victim and try on new behaviors and responses. This important strategy in professional psychodrama is rooted in the fact that a new non-victim role comes from the inner resources of the trauma sufferer, not as a corrective mandate imposed by the therapist.

With such intense pain in their lives, trauma victims need emotional understanding and also clinical expertise to provide the right therapeutic treatment modality at the right time. As leaders in the field, Sierra Tucson's professional staff are caring experts—committed to offering both compassionate care and the most advanced clinical knowledge.

~By Bill Coleman, LMSW, TEP, Psychodramatist at Sierra Tucson

*Bill Coleman is a Certified Psychodrama Trainer and has been a Trauma Therapist at Sierra Tucson since April 2007. He is founding director of La Jornada Institute in Arizona, which trains mental health professionals in the art of Psychodrama. He is also on the faculty of the Action Institute of California. Bill was an Adjunct Professor at Russell Sage College, where he wrote and taught courses in Theater Therapy, and is a graduate of Fordham University Graduate School of Social Work. He lived in New York City for 30 years before coming to Tucson. Bill also had earlier careers in business and served as a Captain in U.S. Army Intelligence during the Vietnam War. He has presented at many national conferences and is the creator of Men-At-Fifty Workshops. Bill instituted a new model of diagramming defensive strategies ("Little Me") for trauma treatment and has also created many psychodramatic structures for substance abuse treatment including a series called "12 Step Psychodrama." Bill assures patients, "I am no stranger to trauma, and you will not be alone as we go on the recovery journey together."*



SIERRA TUCSON®  
39580 S. Lago del Oro Parkway  
Tucson, AZ 85739

800-842-4487

[www.SierraTucson.com](http://www.SierraTucson.com)

*"Compassionate Care, Clinical Excellence"*

Sierra Tucson continues our efforts to  
**"Go Green!"**

- If you receive our email, please **allow** email from **SierraTucson-GreenMail.com**.
- If you do NOT receive our email, **please visit www.SierraTucson.com**. Under "Points of Interest," click **"Sign up - Professional eNetwork."**

*Thank you for supporting Sierra Tucson's sustainability efforts to save natural resources!*

A Member of CRC Health Group  
Dually Accredited by The Joint Commission  
Accredited by the American Academy of Pain Management  
© Copyright 2009 Sierra Tucson®

SIERRA TUCSON  
P R O G R E S S

SPRING/SUMMER 2009

*Meet Nancy Jarrell, M.A., LPC, EAP  
Clinical Director*

In April 2009, Sierra Tucson's staff enthusiastically applauded Nancy Jarrell's promotion to Clinical Director. Since 1996 Nancy has been deeply involved in developing Sierra Tucson's programs. Most recently, she created the Progressions Program, which gives patients an opportunity to learn and practice advanced recovery skills.

With a master's degree in Counseling/Psychology, she is a Licensed Professional Counselor and trained Equine-Assisted Psychotherapist. She has provided Equine-Assisted Therapy to patients since 2000 and has managed the Therapeutic and Recreational Activities Program. Serving as Family Therapist, she developed, implemented, and facilitated the family component for the Program for Sexual and Trauma Recovery. Nancy has facilitated a wide variety of therapy groups in the Program Department, created content and facilitated the Extended Family Program, and also facilitated Family Programs including the Children's Program in both English and Spanish.

Nancy developed a couple's equine therapy component, incorporating Imago theory into the equine process. Nancy presents at national conferences and has co-facilitated workshops in

Couple's Therapy and Equine-Assisted Therapy. In 2006, Nancy was promoted to Assistant Clinical Director.

As Sierra Tucson's Clinical Director, Nancy continues to supervise staff; contribute to program development; and provide facilitation, education, and training in the area of Equine-Assisted Therapy. Nancy has written and published articles and continues to become known as a national expert on Equine-Assisted Therapy.

An avid horsewoman, Nancy owns a horse and enjoys trail riding, yoga, and hiking. She is the mother of two children and still grieves the loss of her daughter three years ago.

Nancy never hesitates to speak of the pride she feels in working with Sierra Tucson's skilled and dedicated staff. "We have a great leadership team to maintain our integrity and clinical excellence and take Sierra Tucson to the next level." Nancy's own dedication is evident through her accomplishments and leadership over the years. "There is nothing more rewarding than the opportunity to see patients healing on a daily basis."

