# Trauma Matters

Spring 2020

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

## Inside this issue:

The Circle of Security Parenting 1, 2

Ask the Experts: An Interview with DCF Commissioner Dorantes 3,4

Foundational Steps to Creating a Trauma-Informed School 4, 5

Telemental Health 5,6

Featured Resource: Time to go to Sesame Street?

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## Circle of Security Parenting:

### Creating Relationships that Equip More Kids to Thrive in Life

Children who have experienced trauma need a relationship that acknowledges their trauma and helps them regain the safety, trust, and joy that has been damaged by the trauma.

A child's relationship with their parent is a core and foundational place for supporting recovery from childhood trauma. Most needed is a quality of relationship that both recognizes the times that a child is experiencing distress from their trauma and also provides the quality of care that successfully addresses the child's distress.

One of the best ways to better understand quality of relationship is the science of attachment. Attachment theory helps us understand what creates strong and healthy relationships as well as the forces that support or hinder that outcome. Attachment theory also helps us to conceptualize how our infancy and childhood attachment impacts us even through our adult years and how it impacts our educational achievement, health, employment success, and our relationships with other people.

Circle of Security Parenting (COSP) is a relatively new intervention designed to give parents attachment-based relationship tools that help them create a quality of relationship with their child that is supportive of secure attachment. What we're realizing is that various relationship-based capacities infants, children, and students need to thrive in life, such as curiosity, self-regulation, joy of learning, perseverance, connectedness, and trust, are built within relationships and best built in a quality of relationship that also supports secure attachment.

At its heart, COSP is a parenting reflection program. The relationship tools provided by COSP help parents to recognize when a child is having distress and equips them with the relationship tools to provide the necessary co-regulation that restores kids to a state of regulation. This helps traumatized kids shift from a state of dysregulation and gain a sense of safety and trust. This internal sense of safety, trust, and joy allows kids to be better equipped to thrive in life with a long-term impact on their success in regard to their education, health, employment, and relationships with others.

For traumatized kids COSP helps parents recognize that a child is distressed and then to provide the protection, comfort, delight, and/or help with organizing their feelings needed so the child's distress is significantly reduced or resolved. For the child this provides an experience of being seen, being believed, being understood, being helped, and being restored to a state of being regulated. In turn, this restored state of self-regulation and sense of safety allows kids' desire to explore their world to kick in. It also supports kids to have a joy of exploring their world and learning from their explorations.

Every parent has an attachment history from their own infancy and childhood. Their attachment history is a force that plays out in their relationship with their child. Adults with a history of a secure attachment from their own childhoods are equipped to provide the quality of relationship that both supports a child to explore their world and successfully deal with the inevitable distresses that occur in life. In turn, this quality of relationship provided by the parent supports a child to have a secure attachment and to be best equipped to thrive in life.

Parents who have a childhood history of insecure attachment have an attachment history that can limit the quality of relationship they can provide to support their child to explore their world. In low risk communities you can reasonably expect

60% of parents to have a childhood history that allows them to provide a quality of relationship that supports secure attachment. Yet, even in low-risk communities, this leaves a large number of parents with a childhood history of insecure attachment. In higher-risk communities you can reasonably expect that a majority of parents will have a childhood history that results in them providing a quality of relationship that supports insecure attachment. Parents' attachment history is a major force in every community.

Every parent brings their own history of how they were parented in their own childhood. This is often a powerful and unconscious force. For parents with a history of receiving a quality of relationship in their own childhood that supported an insecure attachment, this history will often limit their ability to provide a quality of relationship supportive of secure attachment. It doesn't make them "bad parents," but it does limit what they can offer their child in terms of the quality of their relationship.

However, there is hope. COSP devotes one of eight chapters in the intervention to Shark Music. Shark Music refers to the times when a parent interprets their child's safe and developmentally normal behavior or need as a threat. Many times this is happening without the parent's awareness but is driving the parent's behavior. This misinterpretation is connected to the parent's childhood experiences. If a parent didn't have support in their own childhood when having distress, they likely will be uncomfortable when their child is having distress. If a parent didn't have support in their own childhood when exploring their world, they likely will be uncomfortable when their child is exploring their world. COSP helps parents become aware of their discomfort about their child's exploration and/or distress and gain an understanding that their child's behavior is actually not the problem. Rather, COSP helps them realize that their own history of how they were parented is playing out. COSP normalizes this level of understanding by helping parents learn that all parents have Shark Music.

As parents recognize and own their Shark Music, parents can use another relationship tool, Being With. Being With is learning to be with a child in whatever feelings they are having and not trying to make the feeling go away or make the child go away. Thus, COSP helps parents gain awareness that then allows them some freedom to now be with their child in their exploration and/or distress and provide the support needed by their child. This shift allows a parent to now be able to build security rather than insecurity. That is a huge gift to their child. You can access a video about Being With and Shark Music by going to https://www.circleofsecurityinternational.com/resources-for-parents and clicking on the Being With and Shark Music videos. You can also access a wonderful video, Connection and Shark Music, featuring Tonier Cain at https://www.circleofsecurityinternational.com/circle-of-security-model/toniers-story.

COSP also helps parents become aware of when they have created a rupture in their relationship with their child. Maybe their child was upset or crying and needed to be welcomed in and comforted. However, the parent may have sent their child to their room or became angry at their child. This is a rupture. Parents learn that all parents cause ruptures at one time or another. It is part of life. COSP teaches parents that what is needed is repair of the rupture. Parents learn some simple but powerful strategies to create the repair. For parents who never experienced repair in their own childhoods, this can be a profound experience and a great way to use power and love together. What is interesting is the experience of experiencing repair makes kids more resilient and more trusting. A rupture no longer needs to be the end of the story. That is profound and incredibly life-giving.

## COSP in Connecticut

At its simplest, we know infants, children, and adolescents are best prepared to succeed in life when they have a quality of relationship with their parents that is supportive of secure attachment. We also know that their quality of relationship with caregivers, teachers, and other adults in their lives can have a profound impact.

Children with a history of trauma have important relationships with their parents and have important relationships with teachers, caregivers, and other adults in their community. Each of these relationships has the potential to further build and strengthen the capacities kids need to thrive in life.

One strategy being pursued in CT is to build statewide capacity to equip parents, teachers, caregivers, and other adults with the attachment-based relationship tools provided by COSP. Since 2010, over 2,000 people in CT have been trained to offer COSP. CT has seen a growing interest in being trained in COSP from a wide variety of disciplines and settings.

COSP is now creating the possibility of building community-wide efforts to provide parents, teachers, caregivers, and other adults who have relationships with kids with these attachment-based relationship tools as a community strategy to support more kids thriving in life.

## Potential Systems Change and Barriers to Change

We know the quality of relationship a kid has with their parents, teachers, and caregivers has a profound impact on their capacity to thrive in life. While much funding and effort has been expended in CT to address parenting, what has been missing is an intervention that provides attachment-based relationship tools that help parents, teachers, caregivers, and other adults create relationships with a quality that is much more supportive of secure attachment. COSP excels at meeting this need.

Additionally, to achieve significant statewide impact one needs to get an intervention into the hands of many people and into the many places where kids have relationships that can impact their development. As evidenced by the widespread adoption and spread of COSP in CT, COSP is allowing us to do that. While initially focused on parent educators, home visiting staff, and clinicians working with families, COSP is also being adopted by schools, agencies serving childcare providers, prisons, pediatric practices, churches, synagogues, early intervention programs, and supportive housing programs in CT. We believe there is great potential to equip many more adults in CT with these attachment-based relationship tools and to expand the list of adopters to coaches, law enforcement, and other people who have relationships with kids.

While additional funding will be needed to support a more substantial statewide impact, the bigger obstacle is the lack of focus on quality of relationship, as viewed from the lens of attachment theory, as a foundational part of the mission of various state agencies and state leaders. COSP creates the possibility for states to design and build statewide efforts to equip many more kids with the capacities that support them to thrive in life. In turn, this effort would also support state agencies to better achieve the outcomes that are at the heart of their purpose and existence.

**Submitted by Charlie Slaughter, MPH**

## Ask The Experts
## An Interview with
## DCF Com. Vanessa Dorantes
**By Shannon Perkins, LMSW**

**What brought you to the field of social work and child welfare?**

The field itself brought me in. I honestly say that, not from a cliché standpoint. If I think about the fact that my mom and dad were 16 and 17 when they had me and I think about the network within my family and community who worked to make sure that not only was I okay but that my parents were okay. That allowed my mom to go to college and my dad to go off to the Navy. When I think about the work that we do now, I think it's important to reflect on the fact that we (my family) were not involved with the child welfare system because of all those pieces that fit together, but with that profile we very well could have been. So, I think about that full circle all the time – I am one of our kids in its broadest sense. When I think about how I landed here in this Commissioner seat, no idea, but when I think about coming into the field of social work itself, that's it.

**How does this challenging work impact helping professionals and what advice do you have for them?**

This is the most important to understand the complexity of the work that we do and the work/life balance of our staff. The benefit of having a social worker in the seat of Commissioner is that notion of the person within the professional. If we don't take care of our staff, then our staff can't take care of the people who we are responsible to serve. We, in our administration have really thought about Moore's Public Value Strategic Triangle in that you have to have public value from a system standpoint and that public value is anchored on the authorizing body of folks, particularly stakeholders like legislators or our Governor's office who basically endorse and legitimize the support for our work. How does it happen? What's the organizational structure and capacity that we can make this feasible? It's ensuring that my department has what it needs to deliver on that public value. How we do our work operationalizes all of that.

**Can you tell us a bit about the Family First Prevention Services Act?**

Family First is one of the ways that the federal government has started to redefine child welfare. It's the first significant child welfare finance reform of its kind in about four decades. It encourages jurisdictions to redefine prevention in the context of the work we do. Historically, if we think about the way that states or jurisdictions are funded, it's typically through reimbursement for foster care activities. So it is almost an unintended consequence that you are incentivizing the removal of children.

Family First asks us to really think critically about how we work with our partners who use evidence-based programs that have been vetted through a Clearing House to help each state define what their candidacy for foster care would look like. Candidacy just means defining what are the characteristics of the children in your jurisdiction that would give them the highest likelihood for coming to the attention of the child welfare system. We want to define what that is so we can get ahead of it. We want to be to able say, "...community partners, what is it you need to be able to help children and families to stay out of the deepest end of our system?"

So the first component of Family First is really suring up those resources outside of our doors. We talk about narrowing our front door and kind of expanding the front porch and the front yard of service delivery to families. Washington D.C. is one of the first jurisdictions to have their state prevention plan approved by the Federal government. They have a great framework around that front door front porch analogy of thinking of their own community neighbors as allies and asking how do you make sure those evidence-based practices are available for communities outside of our system. If kids have to come into our system, whether it's through investigations or ongoing services for children in care, we have to assure that the service array starts to really get at what it is that kids and families need to be resilient and thrive. And so to try to narrow our front door means that we partner with our stakeholders to be more purposeful on the expectation that there are deliverable services with concrete proof and that they work. Are families better off after interventions? How do we make sure that families have access to those services? Or that our communities have access to those services at equal rates? And that those services keep in mind the cultural competencies and racial differences of our community groups. Family First also focuses our kinship framework by encouraging child welfare practice to prioritize children's placement with relatives when they can't remain safely at home. The administration prior to mine significantly jumpstarted CT's attention to kinship with both maternal and paternal sides of families. As a result, today over 45% of children who are in out of home placement in CT are living with relatives or someone they know.

Another provision of Family First is the use of Qualified Residential Treatment Programs (QRTP) to restrict the use of Title IV-E funding reimbursement for lengthy congregate care stays for children. Again, when my administration took over the reins, the culture of over reliance on congregate care for kids was well in the rearview. We have maintained that less than 7% of children in our care are in non-family settings and are there for treatment purposes.

Because of those advances we're positioned very well to begin to construct a prevention plan with the help of consultants from Chapin Hall building on existing practices in our state. Our five Family First prevention plan development workgroups are composed of over 200 stakeholder voices from across our state.

It's exciting to think about what's possible with Family First and by thinking of prevention in its broadest sense. In CT, we are kind of a microcosm of the country. We have our urban municipalities, we have suburban towns, we have our rural areas— think about all of those and the range of needs for kids and families that we serve in CT. Poverty certainly drives a lot of what we do, but it's not everything. And if we can get this formula right in CT, it can be an illuminating way to be an example for the rest of the country.

We were also recently visited by Dr. Jerry Milner, Associate Commissioner of the Administration for Children and Families— a federal agency within the Department of Health and Human Services, to talk to him about some of the processes we have in CT for this type of thinking in child welfare. In this leadership summit, Dr. Milner challenged us further to think about how we service kids and families from a community-based prevention mindset, Family First is just a tool — a small piece of true reform happening nationally.

**What should providers be aware of when having a trauma informed lens and using interventions that are evidence based to guide their families?**

**Cont. from page 3.** The really good thing about CT is that we are provider rich. We have a tremendously educated and well-informed provider service array. We have a ton of grassroots providers who know their communities well, all the way up through our heavy- hitters that are backed by universities' research. When you think about Yale and UCONN and the myriad of institutions here in Connecticut, we have a wide range of academia who know our families and communities. I think our challenge is being able to connect that web and to connect all our services through all those different mechanisms.

**What would you say are some of the misunderstandings about CT's DCF?**

It's not unique to CT, it's across the board in terms of child welfare. In general, there are two schools of thought. One, is that we are only in this work to remove children and disrupt families. The other piece of that is we take too long to respond and that we leave children in dangerous situations when they should be removed. For me, it's about balancing the narrative and understanding each individual family — what they are dealing with and making sure that our staff are equipped to do the job well.

Truly understanding this work through a lens of trauma is two pronged: It's recognizing, as you asked, the impact of this work on secondary trauma to our staff and the impact of situational experiences of families. If we pay attention to both of those and how we deliver our services, it can only result in better outcomes for kids and families because we're working on the wellbeing of our staff at the same time as we're working on the resilience of our kids and families. There is unlimited potential from both of those if we continue to remind ourselves that both of those are happening at the same time.

**Why do you feel like it's important to have specific efforts for racial justice and fatherhood engagement?**

One of the good things about my role as Commissioner at this time, is that we are not starting from square one. The previous administration laid the groundwork for some really big initiatives like reduction of children in congregate care for long term placement; increase in relative placements, which you know reduces trauma for kids when they are placed with people that they know; and bringing children closer to home from out-of-state placements. We had a significant number of children in out-of-state care that allowed us to really start to think about how do we sure up and strengthen families from within instead of sending children so far away that they couldn't stay connected to people in places that they know. So, with all of those initiatives and all of those things that happened in the previous administration that spanned a decade, we are positioned really well today to carry that work so that we don't move backwards.

Now we build upon that and we know children and families don't sit still waiting for systems to catch up. We must be responsive to where they are in the moment.

In social work we call that meeting families where they are. I think we are well on our way to be able to do that even better because we have all the pieces of the puzzle. Once we can refine and finetune how it is that we deliver our services in conjunction with families and with our stakeholders through our provider network, it makes all of us stronger citizens of CT.

## Foundational Steps to Creating a Trauma-Informed School

For the past year, I have been working with schools and within the school systems to create trauma-informed practices for their classrooms. As a former elementary school teacher, I have a strong understanding of behavioral and structural challenges that teachers face in the classroom. As a clinical psychologist specializing in trauma, I have an important understanding of the impact that trauma can have on children and adults, and how that interpersonal exchange might play out in the classroom.

Educators are now becoming much more knowledgeable of ACEs and continuously express that they have seen an increase in disruptive behaviors in their classroom but lack the understanding as to why this might be or how to address these difficulties. Though financial, structural, and other barriers will exist in our educational systems, there are steps that educators, and particularly administrators, can take to creating more trauma-sensitive schools.

One factor contributing to what teachers see as an increase in trauma in their classrooms is likely economic hardship. Research has demonstrated that poverty is one of the most prevalent ACEs, is a significant predictor of other ACEs, and that states with greater rates of child poverty tend to be linked to greater rates of ACEs (Kirk, 2018). Furthermore, many families began to experience greater financial difficulties after the "Great Recession" at the end of the 2000's and as of the end of 2019 we have learned that the income gap between the rich and the poor in the US has widened to the largest gap it has been in 50 years (Boylan, 2019). These financial difficulties can have a severe impact on whether children have their basic daily needs met, as well as medical, mental, and emotional needs.

Another factor that has had a significant impact on children, teachers, and schools is the aftermath of No Child Left Behind (NCLB) and Common Core Standards. Although standardized testing existed in Connecticut before the early 2000s, it was NCLB (signed into law in 2002) that required yearly testing of all children grades 3 through 12. With this came punitive consequences for already struggling schools. These schools typically had a higher rate of children living in poverty and children of color. In many states, including CT, teachers' evaluations were also tied to the test scores that their students attained each year. This increased the emphasis on test-taking skills and test prep, which has forced teachers to move away from social-emotional learning or play-based learning because of lack of time. One of the most consistent pieces of feedback I receive from teachers is that they feel a pressure to "get high test scores" while handling many other responsibilities which together become too overwhelming to manage. This creates more stress for educators and reduces their own "window of stress tolerance" or capacity to cope with life-stressors such as behavioral difficulties in the classroom (Forbes, 2012). Ultimately, this means that children have not been receiving the necessary social-emotional learning tools and skills that might help them better manage their life-stressors.

So what is a trauma-informed school and what might it look like? It is a school in which ALL adults and staff members, from administrators to lunch and custodial staff, are educated about what constitutes childhood trauma; how it impacts children developmentally, emotionally, behaviorally, and academically; and all work together to provide a trauma-sensitive environment for students. Such an environment includes healthy teacher-student relationships, a sense of safety, regular routines and predictability, social-emotional learning, direct teaching of stress management and coping skills, involving and informing parents of these stress management

**Cont. from page 4.** and coping skills, cultural responsiveness, positive discipline and restorative practices, connecting families to resources outside of school to meet their needs when necessary, and supporting educators to prevent vicarious trauma and burn out. Though this may seem like a lot to implement, many of these elements are already in schools but just need tweaking and refining. Moreover, most do not cost much money or time. At its foundation, this plan calls for strong, positive relationships. This begins with positive relationships among staff member and strong, positive student-teacher relationships rather than a focus on classroom management and control or testing and academics. By engaging with students in a respectful, warm, caring, positive manner, students are more likely to feel safe in the classroom and will not have their brains on high alert for danger. This increases their "window of stress tolerance" allowing them more capacity to engage in pro-social behavior, in academic work, and meet reasonable classroom expectations. Students also need support in understanding emotions – what they are and how to manage them in a healthy manner. This means that students need to be explicitly taught about emotions and emotion regulation so that they can feel more in control over their emotions and so their emotions do not feel dangerous and overwhelming. Some wonderful emotion regulation programs already available to schools include Yale University's RULER system and the Zones of Regulations curriculum.

Also, importantly, educators need to take care of themselves as best as they can so that they themselves do not become overwhelmed or burnt out. One of the most important facets of the workshops that I provide to schools and districts is encouraging educators to be more reflective of their own stressors, life experiences, and potential trauma histories in an effort to create a larger "window of stress tolerance" for themselves. This allows us as adults to respond with compassion and empathy to children's behaviors so that we may think beyond the behavior and have a better understanding of what the behavior is trying to communicate, rather than reacting out of our own emotional place. Therefore, when taken altogether, the four strategy areas that help a school become a successful trauma-informed school are strategies that: 1. Create a positive school climate and culture among the staff and students; 2. Continuously build strong, positive student-teacher relationships; 3. Explicitly teach students emotional awareness and create an environment that reduces their feelings of overwhelm; and 4. Increase teacher support and self-care. Though there is much more that can be discussed, these are the core elements for creating a trauma-informed school.

**Submitted by Viana Turcios-Cotto, Ph.D., Ed.M.**

## Telemental Health: Capturing the Magic of Art Therapy Through a Computer Screen

A few years ago, intrigued by the proliferation of telemental health (TMH), I began to explore the possibility of providing art therapy telemental health (at-TMH) via HIPAA compliant video. I was inspired by the idea of being able to offer art therapy treatment to people who might otherwise not reach out for therapy due to stigma, location, lack of nearby specialty, high anxiety/isolation, busy lives or privacy concerns, and for those who prefer using technology for mental health care.

Art therapy, though a growing mental health field, is a relatively small specialty in comparison to that of social workers, licensed mental health counselors and other mental health professionals. With that in mind, bringing art therapy into the digital world to provide greater access to more of those who would benefit just made sense.

As I began to explore my options, my greatest concern was being able to capture the magic of art therapy through a computer screen.

**Art Therapy**

Over the course of my 15+ year career as an art therapist, I've often heard exclamations from clients (as well as other mental health practitioners) awed by the 'magic' of art therapy for healing and transformation. There is a certain alchemy about being fully present to the art therapy process, facilitated by a professional art therapist, even for those who might initially be skeptical or resistant. There is magic in the silence that befalls the room when one begins to engage in the creative process. The space becomes an oasis of expression as internal experience emerges as external image. When immersed in the process, at times the only sounds are the scumbling of a brush on canvas, the scrape of a pencil on paper, or the smoothing of clay on an armature. At the end of the session, the participant is invited to reflect on and share the creation. During discussion of the artwork, some speak through the metaphor of their pieces to explore the symbolism and potential personal meanings that arise. Some choose to explore traumatic images as they spontaneously emerge. Others allow the imagery to speak for itself as for them, it is all about the inherently relaxing and life-affirming nature of the creative process. Whether cathartic expression of intense emotion, processing of traumatic imagery or something else, something unexpected, the art process and products provide opportunity for insight, healing, and transformation

Though it may seem like magic, art therapy has a foundation in neuroscience and is particularly effective for the treatment of trauma.

**Art Therapy for the Treatment of Trauma**

Art therapy provides several therapeutic mechanisms to successfully treat trauma including but not limited to: progressive externalization through visual expression to facilitate reconsolidation of fragmented memories; reactivation of emotion, including positive emotion, and reduction of arousal; enhance self-efficacy, improve self-esteem and build resilience (Collie, et al, 2006) .

Using non-threatening, progressive exposure through visual form, art therapy allows for patients to reconsolidate the fragmented memories of trauma and create a coherent trauma narrative. Traumatic memories are encoded, often in images, in the deeper, nonverbal recesses of the brain. When an individual recalls a traumatic event, the left frontal cortex, particularly the Broca's area which is responsible for expressive language, shuts down while the right hemisphere, the area around the amygdala, lights up (van der Kolk, 2014). Traumatic events overwhelm the individual's ability to record them as memories that can be talked about - words are inadequate to express and process the 'speechless terror' experienced by a trauma survivor. Art activates all areas of the brain thus facilitating a coherent expression of the trauma through visual representation (Steel & Kuban, 2013).

Creating artwork breaks through emotional numbing and facilitates reactivation of emotion, including positive emotion. Art making is generally experienced as a pleasant, relaxing activity—thus art therapy is an inherently positive psychotherapy. Flow and mindfulness occur when one fully

## Featured Resource: Time to go to Sesame Street?

Submitted by Eileen M. Russo

Sesame Street has done a nice job over the years helping children understand scary things. If you have not been to Sesame Street in a while, now might be the time. Below are some suggested videos that can be found on YouTube. There are also additional videos and resources through Sesame Street in Communities (https://sesamestreetincommunities.org).

- **Big Birds Comfy Cozy Nest**: https://www.youtube.com/ watch?v=ciGL9fCa8uk
- **I can Feel Safe (Elmo)** https://www.youtube.com/watch?time_ continue=11&v=RfIpYplGWQw&feature=emb_logo
- **Count, Breath, Relax (The Count)**: https://www.youtube.com/ watch?time_continue=11&v=n66r5Y6wguc&feature=emb_logo
- **Give Yourself a Hug (Rosita, Elmo, the Count, Abby, Cookie Monster, Big Bird)**: https://www.youtube.com/watch?time_ continue=3&v=VVhkPAge_TY&feature=emb_logo

**Continued from page 5.**

engages in the art therapy process.

In art therapy, emotional self-efficacy is strengthened, self–esteem is improved, and resilience is fortified. The safe container provided by the artwork enables trust to develop. Participants express and witness nonjudgmentally in order to increase mastery of emotions and coping with symptoms. Art engagement involves making choices, solving problems that may seem unsolvable, developing ways to cope with life's stressors, finding meaning and strengthening internal focus of control thereby fostering self-efficacy, and a sense of accomplishment (Hass-Cohen, et al, 2014).

### Telemental Health (TMH)

TMH is variously referred to as online therapy. The US Department of Veterans Affairs (VA) has provided TMH (including creative arts therapies) for over a decade to address the challenge of accessible mental health treatment for veterans who live in rural areas. The Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Defense (DOD), Veterans Health Administration (VHA) and Department of Health and Human Services (HHS), all support the use of TMH. Empirical evidence also supports the use of TMH, including a study which determined TMH is equivalent to and at times even more effective than traditional in-person therapy (Barak, et al, 2008).

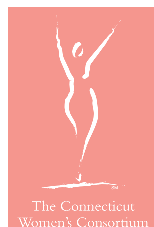
### Art Therapy Telemental Health

I became further intrigued about the potential of art therapy in TMH upon learning about the success of a creative arts therapy telehealth program at a VA hospital in Florida. The Rural Veterans Telerehabilitation Initiative Creative Arts Therapy (RVTRI CAT) Project. demonstrated how art therapy can successfully be adapted to TMH (Spooner, 2019). For me, the truly pivotal experience came in my previous position at the VA where I had the opportunity to work collaboratively with an art therapist in the United Kingdom to co-facilitate a groundbreaking transatlantic art therapy group. These two pilot art therapy groups were held remotely via synchronous video conferencing between veterans in art therapy treatment for chronic post-traumatic stress disorder at the VA and their British counterparts in an art therapy program called Combat Stress in Surrey, UK. The goal of the pilot groups was to explore commonality and universality of experience as expressed through the art therapy process (Lobban & Spinelli, 2017). The groups were a great success and highlighted the magic of art therapy in a telemental health setting.

The success of these groups also elucidated the power of art therapy as a universal language. Cut to today and my current position as the owner and art therapist of a multi-state (and international) online counseling and psychotherapy practice where I work with a diverse group of clients, many of whom are struggling with trauma.

Telemental health is the 'now' and will continue to grow as the future of mental health care. The data demonstrate that TMH is a viable alternative to in-person treatment. Alternative/integrative psychotherapies, including art therapy, continue to grow in popularity and demand due to their effectiveness and holistic mind/body approach. At-TMH expands access for these much-needed services and has the potential to help many people with mental health challenges who would otherwise avoid seeking treatment. At-TMH addresses these concerns by providing increased privacy, convenience, and access to specialty care, while reaching a more diverse population than traditional, in-person interventions.

**Submitted by Laura Spinelli, ATR-BC, LPC, BC-TMH**



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