MICHELE L. GERARD, PH.D., P.C.
Clinical Psychology & Neuropsychology

1750-1 30th Street, #224 • Boulder, Colorado • 80301
(303) 939-9650 • FAX (303) 939-9677

Colorado License #1265
California License #PSY10251

Guidelines for Management of Evaluation/Treatment in Survivors of Multiple Trauma
i.e. How to Get the Patient Better Faster When This is Another in a Series of Traumas

Suspect a history of multiple trauma (these can be a series of: prior accidents/life threatening illness; losses of loved ones; sexual, physical or emotional abuse; severe deprivation or any number of traumatic events) whenever you have a patient who has sought treatment from several health care providers; has involvement of multiple organ systems; when the symptomatology is recurrent or does not respond well to treatment; is without clear physical signs, lab results or structural abnormalities; seldom a year goes by without their seeking medical attention; and when the conditions are classic for psychosomatic illness. Remember, however that survivors of multiple trauma also can have physical illnesses that have nothing to do with the Trauma Response. The actress Sharon Stone is a perfect example. She reportedly had been a high reporter of symptoms and one day called her ex-husband complaining of the worst headache of her life. He reportedly said, "Yeah, yeah" and did nothing. Ms. Stone became quite ill and needed brain surgery that she did not get for three days after the call to her ex-husband because she was too weak and "out of it" to call.

Take their symptoms seriously and also make sure that they are getting the necessary evaluation and treatment for their entire condition. Also remember that years of tension and perception of threat undermine physical health such that many survivors develop autoimmune disorders or other medical conditions simply because their nervous system cannot withstand the onslaught of stress. This is not "all in their head."

The following is based on over 35 years of training and experience in the rehabilitation field. These are guidelines only and are not meant to be substituted for the professional opinion of a qualified health care provider. In my experience, outcome is maximized and the unfortunate development of "taking on the sick role" may be minimized through these interventions:

1. Determine who will be the medical case manager, i.e. in charge of coordination of medical care, oversight of treatment modalities and medication. This needs to be someone who is willing to stay on top of who is providing medical treatment and what happens in that treatment. It is essential that the "right hand knows what the left hand is doing."

2. Determine who will be the rehabilitation case manager, i.e. in charge of coordination of all other care and who will work closely with the medical case manager. In some cases, the medical case manager may want to take on all the duties of case management but physicians usually do not have the time to do all of the extensive consultation/liaison required.

3. Gather the entire medical, academic, social, vocational and psychological, especially trauma, history and records. Use of collateral historians (loved ones) is often helpful, as the patient may not have complete recollection of vital points, and due to trauma may not be able to give a sequential history. Have the patient complete something like the attached Record of Rehabilitation Contacts with the help of loved ones if possible to include information from the most recent trauma but also to document prior treatment.

4. Insure that a complete review of relevant records and patient history has been made before making treatment/medication recommendations if possible. Carefully review historical information provided by the patient and determine if further information is needed. Carefully

note inconsistencies. Use your instinct and intuition if something just doesn't add up and keep digging for the vital information. If treatment has failed in the past, have a clear understanding as to what went into that so that future treatment might be as effective as possible. If there have been recurring physical ailments (chronic conditions), determine if they occur on a regular or semi-regular basis (Seasonal? At anniversary dates of one of the traumas? Every few months?) and/or what emotional triggers/stressors might co-occur or pre-date the physical ailments. Note whether physical symptoms decreased in the past with the use of antidepressant or mood stabilizing medication.

5. Determine what the patient's strengths/resources are and make sure that they are hooked into them. When a new trauma occurs, choice or reaching out effectively can get derailed. Pull in loved ones, co-workers, spiritual resources and continue to insure that they remain in place. When trauma survivors feel alone/abandoned, increased physical symptoms may surface to "cry out" their pain. This can undermine the rehabilitation you are providing. Movement is a resource to the nervous system (moving bodies are alive, inactive bodies may be preparing for death as far as the nervous system is concerned). Consequently, some form of safe movement can be helpful as long as it does not compromise the physical condition.

6. Order evaluation as necessary to determine exactly the etiology and nature of the patient's challenges. Such evaluations may need to be more comprehensive and exhaustive than usual given the complicated nature of cases in survivors of multiple trauma. Really try to figure out what is up before launching into treatment. However, keeping the patient comfortable and progressing is also quite important so use your best judgment. Invasive procedures particularly need to be carefully considered and so does medication management in this patient population. Survivors of multiple trauma may be at risk to overuse pain, anti-anxiety and anti-spasm medication. However, I have seen pain patients for whom regular doses of medication do nothing, and are not seeking drugs in an addictive way. In fact, most of my patients would rather not be taking medication. In addition, these medications have side effects that can make their emotional modulation more difficult. Be careful that you are aware of all previous studies that have been done, prior medications that have been prescribed and their effects.

7. Determine if lifestyle issues are complicating matters, i.e. alcohol consumption, nicotine, caffeine, poor eating habits, amount/quality of sleep (dog sleeping on the bed interfering with sleep?), abusive partner, stress at work, emotional losses, etc.

8. Determine what impediments to getting better may exist, i.e. would the patient have to finally face some difficult challenges? Even getting out from under chronic pain may mean that the patient finally must face the emotional consequences of the trauma and that might be too overwhelming. Unconsciously, it may seem easier to focus on physical symptoms. Ask, "How will your life be different without these symptoms?"

9. Make sure that the case manager collects a problem-oriented comprehensive treatment plan from each health care provider preferably in the attached format (see Treatment Plan form available through the SYCOM company or attached brief treatment plan). It is helpful to have each problem stated in quantifiable terms (Problem: patient has neck pain 75% of the time. Prior to the DOL (date of loss) the patient was in pain 5% of the time. Objective: Patient will be in pain less than 20% of the time. Action: 1. Physical therapy exercises. 2. Develop skills for pain management, 3. Determine activities that aggravate pain, etc.). In this way, everyone is clear as to how the treatment is working to accomplish functional gains and that progress is quantifiable, i.e. it's not hard to tell if you are hitting the objectives. If you are not, then the treatment plan needs to be revised with alternative action plans. The case manager should collect and distribute

the treatment plans to everyone in the treatment team and then track progress in case management sessions. That means that **everyone** needs to cooperate with documentation.

10. Typed notes are a godsend when they are shared among the treatment team. In this way, it's very easy to determine if progress is being made and what is coming up to thwart it. At the very least, the case manager should type his or her notes and this can serve as a summary to the rest of the treatment team. It often happens that when one treatment team member becomes aware of a difficulty encountered elsewhere in the rehabilitation plan, (s)he may be able to do something to impact it.

11. Case conferences should be held at least every six months and every three months is a lot better. In some cases, the team may need to meet monthly. You will be amazed at what comes up. Survivors of multiple trauma often share a very important piece of information with only one health care provider that is essential for everyone to know in order to maximize the effectiveness of treatment. See the attached Summary of Treatment Plan for Case Conference form that helps everyone on the treatment team know what others are doing, avoid duplication of services and keep everyone on track. Case conferences that include the team only for the first hour and the patient with the team for the last 30 minutes seem to work really well. In addition, when the patient sees the team as a united front, understands rationales for treatment choices or terminations, and has input, their compliance is maximized in my experience.

12. Trauma treatment. Trauma treatment. Trauma treatment. I probably should have put this at the top because without it, you may be able to settle down physical/cognitive symptoms but eventually rehabilitation is just going to be palliative because the underlying etiology behind some of the symptomatology will endure. There are many forms of trauma treatment. Let the psychological evaluation drive the choice of the treatment that is most likely to work. When in doubt consider the Brainspotting Technique (https://brainspotting.pro) or the Somatic Experiencing Technique. See the Foundation for Human Enrichment's website at www.traumahealing.com for information and resources. EMDR (Eye Movement Desensitization and Re-processing) is an empirically validated technique for trauma. See their website at www.emdr.com and www.emdria.org. However, in my experience, EMDR can be too activating for survivors of multiple trauma. I have seen skilled EMDR therapists using "Resourcing" techniques to prepare patients for the full protocol of EMDR with success. There are other forms of trauma treatment as well but these two are the ones with which I have the most experience. Be sure that the trauma practitioners are certified and experienced with this challenging population.

13. Be prepared for a two-steps forward, one step-back course of treatment. Work very hard to stage treatment and keep appointments to what is absolutely necessary. Work to make their rehabilitation like Day Treatment but only Monday, Wednesday, and Friday, so that they have time to recuperate their limited stamina. Make sure that treatment is time-limited as survivors of multiple trauma sometimes get in a loop of un-ending treatment. Expects plateaus from time to time but if progression stops for more than four to six months, it is time to re-group and maybe pull the plug. Unfortunately, there are some survivors of multiple trauma who for a variety of reasons cannot move through their trauma and are so closely wedded to it that no amount of treatment is going to help them progress. In my experience, sometimes if I back off of someone in this stance, years later they come back in a different frame of mind. In addition, sometimes survivors of multiple trauma need a break from their rehabilitation in order to begin progressing again. One or two weeks off of all appointments can sometimes breathe life back into what is an exhausting process.

14. The key is to really stay on top of treatment progress. These individuals have been through a lot and do need constructive encouragement without coddling. Create the expectation that they have

what it takes to progress, that they will not be alone in the process but YOU ARE NOT GOING TO DO IT FOR THEM. Set realistic goals and make them accountable for reaching them. Be assertive about pointing out when they are consciously or most often unconsciously sabotaging their progress (this is a feature of the Trauma Response) out of fear that working through trauma may feel annihilating .

15. Read up on trauma. See Dr. Robert Scaer's article, "The Whiplash Syndrome: A Model of Traumatic Stress" in The Journal of Cognitive Rehabilitation, July/August 2000 and his book "The Body Bears the Burden." See Drs. Diane Poole Heller and Larry Heller's book "Crash Course: A Self-Healing Guide to Auto Accident Trauma & Recovery" and Dr. Peter Levine's book "Waking the Tiger: Healing Trauma." There are many other examples of great books, including Dr. David Grand's book, "Brainspotting: The Revolutionary New Therapy for Rapid and Effective Change," and Dr. Gabor Mate's book, "When the Body Says No: Exploring the Stress-Disease Connection." For fascinating information on how the brain-body connection works see Dr. Daniel Siegal's "Mindsight: The New Science of Personal Transformation." Not much time for reading? Some of these books are available as books on CD or for download.

16. Survivors of multiple trauma when they have recovered are generally very appreciative and will sing your praises for having helped him through some very difficult times! They can be a very rewarding part of your practice.

For further information, I am available for consultation at 303 939-9650 or braindr2@gmail.com.

Michele Gerard Ph.D.
1942 Broadway #314
Boulder CO 80302

www.MicheleGerardPhD.com

RECORD OF REHABILITATION CONTACTS

Name:
Date of Birth:
Insured:

Date of Loss:
Claim Number:
Date:

Please use the following template (use additional pages as necessary) to report in chronological order (starting with the first contact after the incident and then the next, etc.) the health care professionals that you have contacted for your condition (feel free to ask your professionals to help you complete this form). Please print legibly or type your response. A Word for Windows document is available for this form. Thank you.

Name, address and telephone number of professional/facility:

Rationale for seeing this professional/going to this facility; i.e. went to local emergency room for evaluation/treatment; had a previous treating relationship; was referred by a particular professional; self-referred:

Area of specialization of the professional/facility:

Date first seen and length of appointment (please arrange these pages in chronological order):

Symptoms you reported (please be specific including when they started, how intense they were, how often you were having them):

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Preserved areas of function, i.e. key areas of function that weren't a problem at that time:

What happened in this first appointment, i.e. what kind of evaluation or treatment did you receive?

Tests administered and their findings:

First Contact Continued:

Conclusions of the professional/facility:

Diagnosis (please also include ICD-9 or DSM-IV codes if you know them):

Recommended further evaluation/treatment? If yes, what kind and with whom?

How often did you treat with this provider?

What was the treatment plan, i.e. what were the goals and interventions that were planned (please attach if you have the professional's written treatment plan)?

Total number of sessions to date:

Any missed appointments? If yes, why?

Referrals made to other professionals and goal of the referral:

Functional gains associated with this treatment, i.e. improved sleep, better range of motion, decreased pain (how did you get better?):

Limitations of the treatment, i.e. ways in which it did not seem to be helping, why didn't certain symptoms get any better?

Date of last session:

If you stopped going to this professional/facility, why did you stop?

RECORD OF REHABILITATION CONTACTS

Name:
Date of Birth:
Date:

Date of Loss:
Claim Number:
Page:

Use this page for the next contact you made:

Name, address and telephone number of professional/facility:

Rationale for seeing this professional/going to this facility; i.e. went to local emergency room for evaluation/treatment; had a previous treating relationship; was referred by a particular professional; self-referred:

Area of specialization of the professional/facility:

Date first seen and length of appointment (please arrange these pages in chronological order):

Symptoms you reported (please be specific including when they started, how intense they were, how often you were having them):

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Preserved areas of function, i.e. key areas of function that weren't a problem at that time:

What happened in this first appointment, i.e. what kind of evaluation or treatment did you receive?

Tests administered and their findings:

Name: Date:
Date of Loss: Page:

Next Contact Continued:

Conclusions of the professional/facility:

Diagnosis (please also include ICD-9 or DSM-IV codes as well if you know them):

Recommended further evaluation/treatment? If yes, what kind and with whom?

How often did you treat with this provider?

What was the treatment plan, i.e. what were the goals and interventions that were planned (please attach if you have the professional's written treatment plan)?

Any further symptoms that developed:

Total number of sessions to date:

Any missed appointments? If yes, why?

Referrals made to other professionals and goal of the referral:

Functional gains associated with this treatment, i.e. improved sleep, better range of motion, decreased pain (how did you get better?):

Limitations of the treatment, i.e. ways in which it did not seem to be helping, why didn't certain symptoms get any better?

Date of last session:

If you stopped going to this professional/facility, why did you stop?

TREATMENT PLAN

Client Name ______________________________ Date ______________

Problem	Objectives	Short Term	Long Term	Action/Responsible Staff Member	Target Date	Date Resolved

SAMPLE

I have participated in the formulation of this plan, and understand and agree to its provisions.
The plan shall be reviewed and updated every __________ month(s).

Next Review Date

Signature of Primary Counselor	Date	Signature of Client	Date	Signature of Physician/Supervisor	Date

Item 4713 • 1/90 SYCOM® Madison, WI Printed in U.S.A.

SUMMARY OF TREATMENT PLAN FOR CASE CONFERENCE

Name: Date:
Claim No: DOL:

Name of Treatment Team Member:

Specialty:

Date Evaluation/Treatment Initiated:

Current Symptomatology/Problem List:

1.

2.

3.

4.

5.

Planned Interventions:

1.

2.

3.

4.

5.

Duration of Treatment/Number of Sessions Required to Meet Stated Goals:

Anticipated Date of Return to Work: 2-4 Hours-
(If applicable) 5-8 Hours-
9-12 Hours-
13-16 Hours-
17-20 Hours-
20-25 Hours-
25-35 Hours-
36-40 Hours-

Anticipated Discharge Date:

Percent of Treatment Directly Related to __-__-____ Injury:

Prognosis With Treatment (circle one): Poor Guarded Fair Good Very Good Excellent

Signature Date: