Written Testimony of Michele Solloway, PhD, MPA, SEP, RPP, LMT
On behalf of the
Somatic Experiencing™ Trauma Institute

March 6, 2020

Before the Senate Judicial Proceedings Committee
In Support of

S.B. 918
An Act Establishing the Maryland Commission on Trauma-Informed Care

Good afternoon. Chairman Smith and members of the Committee, thank you for this opportunity to discuss Senate Bill 918, which would establish a state commission on trauma-informed care with the primary purpose of assisting in the development and coordination of a statewide trauma-responsive strategy.

My name is Michele Solloway. I am a resident of Baltimore, a trauma and massage therapist licensed by the State of Maryland (#MO5987), and a member of the Board of the Somatic Experiencing™ Trauma Institute (SETI), a national 501(c)(3) nonprofit organization of over 7,000 members dedicated to providing state-of-the-art professional training and public education regarding specialized treatment for resolving and healing trauma. I also have nearly 30 years' experience as a health services research with a background in the neurosciences and a research focus on child and family health, vulnerable populations, workforce issues, and most recently adverse childhood experiences (ACEs).

As a researcher and someone who has worked with trauma patients for nearly 20 years, I can testify to the tremendous need for state involvement in a health issue that affects a broad spectrum of Americans across socio-economic, ethnic and racial demographics. In particular, the broad cross-section of state officials and outside experts and community activists who would participate on the Commission, assuring that the necessary coordination, communication, and staffing support established at the outset is essential.

While many will be testifying today about the impact of trauma on themselves and/or their communities, I would like to address some fundamentals of trauma, why it is so important to understand how trauma works and how it manifests, and focus more specifically on the needs of service providers who work with traumatized clients.

Trauma does not know or respect boundaries of age, race/ethnicity, income or wealth, type of job, social status, experience, religion, place, space, time, or privilege. Trauma is universal and a foundational experience. We all have it – some or most of it we have resolved and some of it we continue to carry with us. To the extent that we do not resolve trauma, it becomes a lens or filter – in neuroscience terms, wiring in the brain – through which we experience and respond to life.

There are many kinds of trauma: (1) Shock or acute trauma: an event that happened too fast and too soon, and overwhelms our capacity to cope and respond; (2) Developmental trauma, due to an ongoing misattunement between a child and primary caretaker; (3) Chronic trauma: repetitive and occurring over a long period of time; (4) Complex trauma: multiple traumatic experiences without the time to heal between them; and (5) Systemic or Institutionalized trauma, such as racism, sexism, ableism, homophobia, transphobia.

Systemic trauma is particularly devastating, can be passed down through generations, and can alter DNA (epigenetics). Systemic trauma compounds one's response to immediate threats and stress by lowering the threshold for activating the "flight, fight or freeze" response. Systemic trauma might be considered analogous to a backdrop on a stage set. It is pervasive and a foundation on which all else rests.

Regardless of the source, trauma is held in the body and more specifically in the autonomic nervous system (ANS) – the part of our nervous system that operates at an unconscious level. Trauma rewires the brain and more specifically the amygdala, the primitive part of our brain that is always scanning for threats. And because of this, you can't "think" your way out of trauma; trauma resolution requires body-

centered approaches. This is also why experiencing trauma as a child is even more problematic – because children's brains are not fully developed and trauma can interrupt or stunt brain development.

Trauma reduces one's capacity to experience strong feelings, emotions or sensations without being triggered into a "flight, fight or freeze" state – what we call a "trauma response" – creating a dysregulated nervous system. People with trauma will respond to external stimulus, emotions, and sensations faster and more strongly than people with a healthy regulated nervous system. This in turn reduces their ability to make deliberate choices in how to respond to a perceived threat. It also is more difficult for someone in a trauma state to re-regulate their nervous system back to a healthy state. Somatic Experiencing® (SE™) is resiliency-based integrative treatment for ANS dysregulation for the different kinds of trauma mentioned above. SE™ focuses on re-establishing and expanding an individual's innate capacity for ANS and emotional regulation. A brief report on the effectiveness of SE™ to reduce PTSD, depression and anxiety, and improve quality of life in veterans is provided at the end of this testimony. Additional research on the effectiveness of SE™ is available on the SETI website at www.traumahealing.org/resources/.

Our reactions to a traumatic or stressful event always derive from the impulse to survive. Behaviors that helped someone navigate a traumatic or highly stressful event might be useful in the moment of the event, but later, in a different setting or context, the same behavior may be dysfunctional. Often, these dysfunctional responses are automatic and not a matter of choice. This is what it means to be in a trauma state.

Trauma typically results in and gets expressed as symptoms, which can include (but are not limited to) depression, anxiety, hypervigilance, hyperactivity, insomnia, addiction to drugs and/or alcohol; anger, rage, or high reactivity; detachment or non-responsiveness; dissociation – being out of body; post-traumatic stress disorder (PTSD); social isolation; an inability to have positive relationships or connection with others; poor job performance, burnout, or absenteeism; chronic pain; and feelings of hopelessness or being stuck.

It is critical to understand what trauma "looks like" because people with trauma behave in ways that are frequently misunderstood. They are expected to do things by their peers, supervisors or authority figures, or to behave in ways they can't possibly comply with and that actually are harmful or re-traumatizing. Telling someone to behave differently is not effective and will not yield the result you are looking for. There has been some movement in raising awareness of trauma to ask not "what is wrong with you?" but "what happened to you?" Creating cross-sector trauma-informed and trauma-responsive systems of care through this statewide initiative can bring an important focus to these issues.

Service providers and those who work with or treat traumatized clients all day are a particularly important focus for this proposed statewide effort. These include (but are limited to) healthcare providers, foster care and welfare workers, public health workers, teachers, EMTs, police fire, and justice-involved workers. These workers are of high concern because they have dual exposure issues. Typically, service providers have higher levels of historical trauma (or ACEs) which may have actually led them into service professions. Additionally, on the job, service providers often experience vicarious or secondary trauma from constantly being "on high alert" and hearing about or dealing with other people's trauma. Without active self-care initiatives or opportunities, service providers will suffer from compassion fatigue, burnout and reduced effectiveness over time. Service providers deserve specific training and assistance to be able to continually be effective at their jobs.

Thus, it is particularly essential to involve the broad cross-section of state officials, outside experts and community activists to participate on the Commission and to assure that the necessary coordination, communication, and staffing skills to support this important work. SETI fully supports this effort.

In closing, I'd like to thank Senator Carter for introducing this legislation and I hope that the Committee will support this ground-breaking legislation as it moves through the Senate, and it is hoped, through the House and to Governor Hogan for his signature. I would also like to note that SETI is fully supportive of this bill.

I would be happy to address any questions by members of this Committee and am available for further discussion if desired.

Thank you.

Michele Solloway

Michele Solloway, PhD, MPA, SEP, RPP, LMT

Board member, Foundation for Human Enrichment
Somatic Experiencing™ Trauma Institute
www.traumahealing.org
msolloway@traumahealing.org

Owner, Renew Your CORE (Creativity, Opportunities, Resilience, Effectiveness)
www.renewyourcore.com
msolloway@renewyourcore.com

3021 E. Baltimore Street
Baltimore, MD 21224
503-544-8989
sollowaymi@gmail.com

Written Testimony for Maryland Senate Bill 918:
An Act Establishing the Maryland Commission on Trauma-Informed Care

Michele Solloway, PhD, MPA, SEP, RPP, LMT
Example Research on the Effectiveness of Somatic Experiencing™

Preliminary Data on Efficacy of *Returning Home*:
A Somatic Experiencing® Trauma Healing Retreat for Veterans

(Abstract Submitted to the American Public Health Association)

Authors:
Alexandra Whitney, Ph.D., SEP; ERGOS Institute, Boulder CO.
Michele R. Solloway, PhD, MPA, SEP, RPP, LMT/BCMBT, Senior Scientist/Consultant, SUNY Downstate Health Sciences University, College of Nursing;
Michael Changaris, PsyD. Chief Training Officer, Integrated Health Psychology Training Program, Wright Institute

Background: Somatic Experiencing® (SE™) is resiliency-based integrative treatment for autonomic nervous system (ANS) dysregulation syndromes including post-traumatic stress disorder (PTSD), anxiety, depression, and physical syndromes like chronic pain and migraines (Briggs, Hayes, & Changaris, 2018; Brom et. al., 2018; Levine, Blakeslee, & Sylvae, 2018). SE™ focuses on re-establishing and expanding an individual's innate capacity for ANS and emotional regulation. Veterans returning home from military service face significant readjustment to civilian life and face disproportionately high mental health challenges, such as PTSD, depression, and anxiety compared to their civilian counterparts (Morin, 2011). *Returning Home* is an intensive, integrative, short-term Somatic Experiencing® treatment protocol designed to address the life altering and debilitating symptoms of PTSD, shock trauma, and stress conditions related to combat and military service based on the work of Cushing et al,, 2018 and Vasher et al., 2017.

Methods: Participants were enrolled using a snowball convenience sample. IRB approval and informed consent were implemented. During the six day retreat, each participant was taught self-regulating skills to decrease trauma symptoms while managing physical discomfort. These interventions addressed basic SE™ concepts of grounding, tracking sensation, pendulation, presence, resourcing, and sensing. The SE 'toolbox' was used with all aspects of the retreat program including daily individual SE™ sessions integrated with equine-assisted learning, yoga, meditation, forest bathing, and group psycho-education. Using a controlled waitlist protocol, outcome measures were collected pre-and post-retreat and at 6-month follow up post retreat. Participation in the retreat and research component was voluntary. This study evaluated symptom reduction in returning veterans with military service-related trauma (PLC-5), depression (PHQ-9), anxiety (BDA-II), moral injury (Expressions of Moral Injury Scale-Military Version), and the extent to which SE increases veteran's quality of life (QOL Questionnaire; Satisfaction with Life Scale). These data reflect early findings from outcomes of the initial retreat; control group data are not available at this time.

Results: The study population (n=21) included 15 males (71%), 6 females (29%), an age range of 24-70 years, a range of 5-30+ years of active service, and a range of 0.5-49 years since discharge, with service in all wars since Vietnam. All participants improved significantly on measures of PTSD, depression, and

quality of life. PTSD (PCL-5) showed a 9.58 point reduction, a change in the clinically meaningful range, with two tailed t-test significance of $p = .006$. Change in depression scores were both clinically and statistically significant, from 13.36 pre-retreat to 9.15 post-retreat ($p = .00002$), from above diagnostic range (mild depression) to below (minimal symptoms). Quality of life scores improved from 64 at pre-retreat to 73.83 post-retreat, representing a statistically significant change ($p = .00004$). Measures of anxiety trended to statistical significance with a reduction in anxiety score between pre-retreat and 6 month follow up ($p = .055$).

Conclusion: Preliminary data indicate that this SE™ treatment program had a meaningful impact on clinical symptoms of PTSD, depression, increased quality of life, and some though not statistically significant impact on anxiety. A brief intensive Somatic Experiencing-based integrated approach shows promise and is worth further investigation.