

Lisa Najavits, *Seeking Safety*

**“THEY CONSTANTLY TELL THEIR
STORIES...SOMETIMES EVEN WITH
WORDS.”**



THE STAGES OF CHANGE

(Prochaska, DiClemente, Norcross)

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Termination
- Relapse/Recycle

NORMAL RESPONSES!

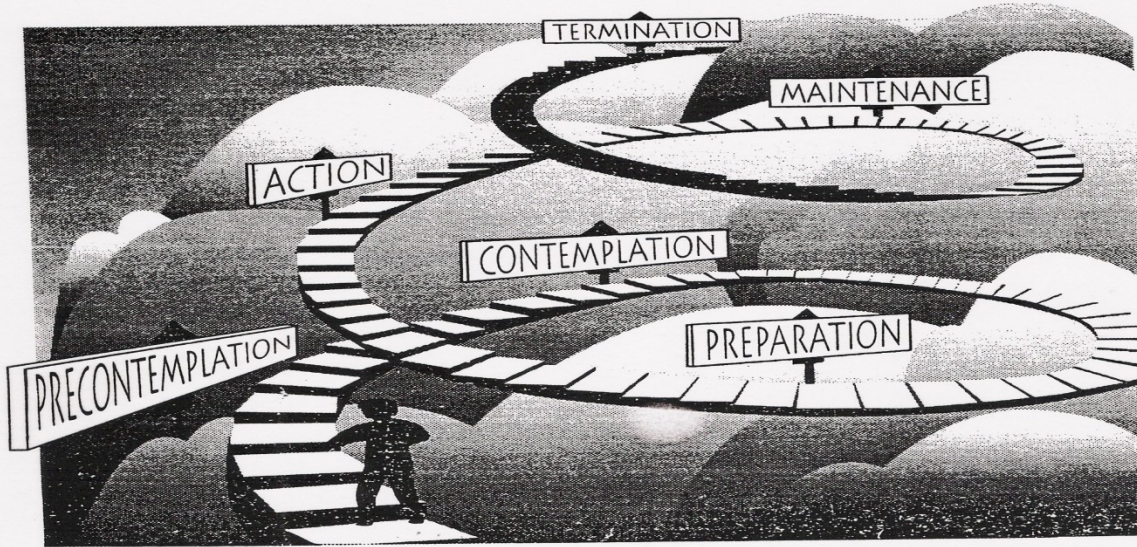
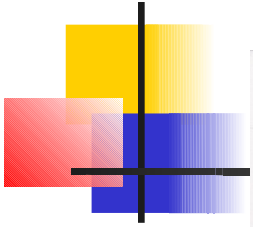


FIGURE 1. The Spiral of Change



Drug, Set, Setting

- Drug
 - Substance; cut; route of administration; legality
- Set
 - Physiology; psychology; culture; expectations; motivation
- Setting
 - Environment; w/whom & where; attitudes to use

*Zinberg, N. (1984) *Drug, Set, Setting: The Basis for Controlled Intoxicant Use*. New Haven: Yale University.



Good Drug Treatment:

- Defines success as “any positive change”
 - Sees obstacles like poverty, mental illness, racism, & more with trauma leading to: hopelessness, despair, self-destruction, self-defeating behaviors, abuse of others, & more
 - Understands that relationships, self-esteem, and self-care are needed to increase motivation for change
 - Appreciates that change is slow, incremental, and has setbacks
 - Knows setbacks (relapse) are the rule not the exception!



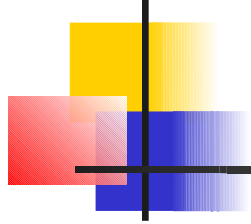
Good Drug Treatment:

- Start where the client “is”
 - Assess the extent & meaning of dx use for client
 - Desired goals
 - Level of ambivalence re: change(s)
- Share expertise with client in this process ONLY with permission!
 - Help client decide best choice for her drug use/beh change
 - Be flexible with goals and method of achieving them
- Assist client implement their Change Plan
 - Realize relapse is expected part of change process
- Appreciate & understand - not overcome – resistance



Understanding Change:

- Denial is typically a product of shame & punitive sanctions (encourages lying not truth-telling)
- Ambivalence and resistance to change are natural, not pathological
- Addiction is a relationship. Tx must offer the same support or respect that it can't



Trauma; PTSD; SUDs;
and Mental Illness

DEFINITIONS...



What is Trauma?

- An event or series of events that threaten you, perhaps even with death – that causes physical or emotional harm and/or exploits your body and/or integrity
- Trauma is pervasive and life-altering
- Trauma has been reported by 55-99% of female substance abusers (Najavits et al, 1998)



More on Trauma

- Trauma betrays our beliefs, values, and assumptions – trust – about the world around us
- Trauma leads us to engage in sometimes less healthy behaviors to help us through our reactions to these events. These behaviors
 - Are an adaptation not a pathology
 - What kept us alive to get us to you!



PTSD Symptoms - simplified:

- ***Re-experience***

- recurrent and intrusive recollections of and/or nightmares about the event
- flashbacks, hallucinations, or other vivid feelings of the event happening again
- great psychological or physiological distress when certain things (objects, situations, etc.) remind them of the event.

- ***Avoidance***

- persistently avoiding things that remind them of the traumatic event
 - including thoughts, feelings, or conversations associated with the incident to activities, places, or people that cause them to recall the event



PTSD Symptoms (con't):

- general lack of responsiveness signaled by an inability to recall aspects of the trauma
- decreased interest in formerly important activities
- feeling of detachment from others, a limited range of emotion, and/or feelings of hopelessness about the future
- ***Increased arousal***
 - Includes difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, becoming very alert or watchful, and/or jumpiness or being easily startled

Note: Folks w/PTSD are at increased risk for suicide



Post-trauma, women with SUDs...

- Improve less
- Worse coping
- Greater distress
- More positive views of substance use (understandably)



Connections between SUDs & Trauma

- Witnessing/experiencing childhood family violence
- Childhood physical and emotional abuse
- Women in chemical recovery
 - Typically have history of violent trauma
 - Substances used to numb or dissociate - *medicinal*
- Violence often seen as a “natural” part of life
 - Coping mechanism for frustration and anger



What is Mental Illness?

- A medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others, and daily functioning
- Serious mental illnesses include: major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder

Thanks to the National Alliance for the Mentally Ill
@ www.nami.org




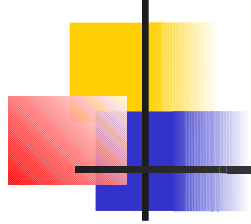
Treatment for MI?

- Medication psychosocial treatments such as cognitive behavioral therapy (CBT), interpersonal therapy, peer support groups, and other community services
- Availability of transportation, diet, exercise, sleep, friends, and meaningful paid or volunteer activities contribute to mental illness recovery

Thanks to NAMI @ www.nami.org

Women with SUDs/Mental Illness

- 
- Need safety to disclose chemical use
 - May become disruptive when trauma hx becomes evident
 - Face tremendous stigma
 - Seen as bad mothers or people
 - Seen as resistant to treatment or unmotivated
 - Often most need these services
 - among those least likely to seek/receive services



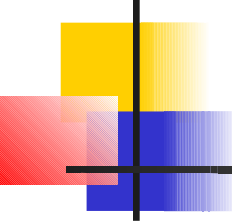
in fact, IT OFTEN GETS WORSE!

PTSD DOES NOT GO AWAY WITH ABSTINENCE;



Adoptive coping strategies:

- Avoidance or 'denial' (numbness)
- Substance abuse & other addictive behaviors
 - Compulsive eating/food disorders
 - Compulsive risk-taking behaviors
 - Risky sex, driving fast or recklessly
 - Gambling or reckless investing/get-rich schemes
- Self-harm: cutting
- Control obsession
- Suicidal thoughts and/or attempts



Dissociation (complete numbing)

- Not mentioned in DSM-IV as symptom of PTSD though sx of acute stress d/o
- PTSD actually is a dissociative disorder not anxiety d/o?
- Crucial to understand process – it's the most severe consequence of PTSD



PTSD, Trauma & Consequences

- Varies due to:
 - Age of survivor
 - Nature of trauma
 - Response to trauma
 - Support to survivor afterwards
- Survivors suffer reduced quality of life
- Body signals can cause relapse
- Ability to orient to safety & danger decreases



Trauma-Informed Services...

- Sees the whole person, understanding the context of all behaviors/coping strategies
- Provides respectful & accurate empathetic listening to best enter the world of the client/consumer
- Focus is on the *client/consumer* – not the symptoms, behavior or problems - & reduction of symptoms not treating an illness



Trauma-Informed Services...

- Ask: Are our policies and procedures, program, hiring practices, etc. all in line with preventing the re-traumatization of the client/consumer?

OR

- Are we letting our rules – defined as the need for “safety” - actually mimicking any dynamics of an abusive relationship?



4th Step for Agencies:

- Do we ever betray a trust (ie, exit users who admit to using)?
- Do we ever keep secrets from client/consumers?
- Do we always believe our client/consumers?
- Do we really listen to our client/consumers/affirm their voices re: their treatment & other important life decisions?
- Do we continuously ask client/consumers about their goals & how they see getting them?



Traditional Trauma Approach

- Deficit model; focus is on problems
- Single trauma event = single effect
- Expected and definable course of treatment & recovery
- client/consumer is defined by their problem (ie, liars; borderline; addict; resistant, etc)
- Treatment is typically crisis driven



More on Traditional Approaches

- Goal is stabilization or reduction of symptoms
- Staff relationship to client/consumer is hierarchical (like whom??)
- PTSD is lens through which we view client/consumer
- Safety and trust in agency is a given & expected but not reciprocated



Trauma-Informed Services

- client/consumer's worldview is due to trauma
 - Distrust, danger, confusion and self-blame are normal
- Sees how dealing with stresses of trauma causes client/consumers to adopt less healthy ways to behave
- Appreciates early traumas inform later complex coping skills, continue to develop over a lifetime
- Understands trauma informs client/consumer's identity even when not realized (example next slide)



Case Example of Unrecognized & Untreated Trauma

- *Sexually abused 12 y.o. girl dissociates during the attack. Later in school, when she has flashbacks, she again dissociates. This leads to her identification as a child with learning disabilities, a label which stays with her for life, and also leads to no trauma assessment or treatment.*



Scenarios

- Taking the above scenario:
 - As a group, decide how you would treat this client/consumer using a Trauma-Informed Model
- 10 mins to briefly discuss
- Debrief in large group



New Integrated Services

- Emphasis is on whole person – how you lead your life.
 - “How can I come to understand this person fully?”
- Focus not just on functioning
- Agency message becomes “your behavior makes sense given your circumstances.”
- client/consumers begin to see their behaviors as coping and brave, not pathology and unhealthy; no character flaws here (12-Step language)



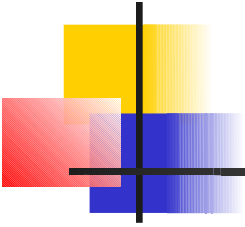
New Integrated Services

- Coping skills and strategies lead to improved empowerment and self-efficacy
- Trauma viewed as complex PTSD resulting from chronic &/or repeated stressors
- Strength-based approach
- client/consumers actively involved in all aspects of treatment planning and services
 - We are equal partners



New Integrated Trauma Services

- Safety guaranteed - not from other client/consumers but from perpetrators
- Priority is on choice and autonomy
- SU/A seen as coping strategy to survive trauma/abuse and treated accordingly
- Agency becomes collaborator, not fixer of loves/savior
 - *client/consumer* becomes Change Agent – powerful!



It's possible but not easy - at first.

**HOW DO WE DEVELOP &
PRACTICE REAL
INTEGRATED SERVICES?**



We believe...

- We have not walked in your shoes so we can't fully understand what you're going through
- You are the *only* expert in your life; we need your help to assist you
- In you & your capabilities , and in your Concerned Significant Others' ability to support you



What works?

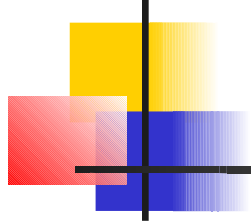
- *Exposure (*most effective*)
- EMDR (not w/schizophrenia or SUDs?)
- Narrative Therapy
- Mourning (not for all)
- Motivational Enhancement Therapy/MI
- Cognitive-Behavioral Therapy (CBT) & other behavior therapies
- *Seeking Safety
- Somatic Experiencing (SE) Therapy (Peter Levine, PhD)
- *Psychopharmacology



Remember:

- PTSD affects about 7.7 million American adults
- Women are more likely to develop PTSD than men
- Some evidence that susceptibility runs in families
- PTSD is often accompanied by depression, substance abuse disorders, or one or more of the other anxiety disorders

Thanks to NIMH @ www.nimh.nih.gov/health



Teaching *Grounding* to
a client (10min)

VIDEO: A CLIENT'S STORY

What can we do?



- Listen more than talk
- Gently help client/consumers link SUD & PTSD
- Discuss current - not past - problems
- 'Listen' to client/consumer behaviors
- Get training!
- Appreciate that substances do solve PTSD symptoms

Language is crucial:



- Abstinent, sober, or drug-free
- Powerful; empowered
- Women united for women
- Supportive relationships
- Not “clean”
- Not “Powerless”
- No “Gossiping”
- Not “enabling” or “co-dependency”



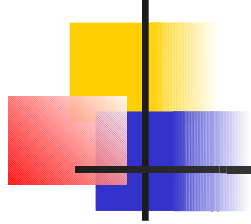
What shouldn't we do?

- Don't explore past trauma(s)
- In general, no psychodynamic work at first
- No autobiographies until stable
- Don't ask about the trauma or the triggers
 - Gently guide conversation to present problems
 - Use complex reflections to highlight strengths

When is someone ready for trauma processing?

Sometimes never!

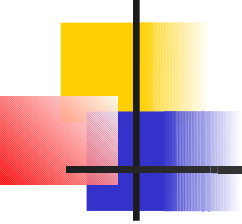
- Able to remain abstinent or moderate for some time
- Able to control some destructive behaviors
- Able to use some coping skills
- Can ask for help
- Is in a system of care (treatment, etc.)
- Willing to begin trauma work
- Has no major current crises, i.e., DV, homelessness



ABOVE ALL, BE CAUTIOUS – GO

SLOW

There is great danger in re-traumatizing clients!



“We should be humbled in the presence of our clients for *they* are the heroes of their lives.”

--- Scott D. Miller

FIRST, DO NO HARM



More we can do:

- Be willing to try new things; model healthy change for client/consumers (which means show them it's hard but do-able)
- Believe the client/consumer & their CSOs are their most important resource
- See opportunities not problems
- Build alliances with other disciplines (MDs, AOD, other agencies, etc)
- Be flexible with staff re: how they approach the job
- Try walking in the client/consumer's shoes
- Know we can't know everything – & be OK with that
- Have a great sense of humor!



ACKNOWLEDGEMENTS

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