

“They constantly tell their stories...sometimes even with words.”

Lisa Najavits, *Seeking Safety*

Definitions...

Trauma; PTSD; SUDs;
and Mental Illness



OK to reproduce in its entirety only please!

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!

More on Trauma

- Childhood emotional trauma can shorten lifespan according to Janice Kiecolt-Glaser, PhD (Bottom Line Personal, Vol 31, #21, 11/1/10)
- Get help!
 - Psychotherapy
 - Exercise
 - Meditation and yoga
- Multiple traumas can shorten life by 15 yrs
 - Cardiovascular disease
 - Type 2 Diabetes
 - Osteoporosis and more

Possible Responses to Trauma

- Intense fear; hypervigilance
- Feelings of helplessness
- Anxiety
- Worry
- Intrusive thoughts & memories
- Flashbacks
- Depression

More Possible Responses to Trauma

- Anger or rage
- Nightmares & Night Terrors
- Detachment & Dissociation
- Substance Use & Misuse/Abuse
- Unusual sexual behavior
- Difficulty with relationships
- Others



OK to reproduce in its entirety only please!

What is PTSD?

- DSM-IV*
 - A. Exposure to a traumatic event in which both of the following are present:
 - 1. Person experienced, witnessed, or was confronted w/event of actual or threatened death or serious injury, or threat to physical integrity of self or others.
 - 2. Person's response involved intense fear, helplessness, or horror.

*Note: this is an older edition. Currently used is the DSM-IV-TR. The DSM-V is due 2013.

PTSD

- B. 1 or more of the following:
 - 1. Recurrent & intrusive distressing recollections of the event, including images, thoughts, or perceptions.
 - 2. Recurrent distressing dreams of the event.
 - 3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociate flashback episodes, including those that occur on awakening or when intoxicated).

PTSD

- B. 1 or more of the following:
 - 4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect for the traumatic event.
 - 5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

PTSD

- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness as indicated by 3 or more of the following:
 - 1. Efforts to avoid thoughts, feelings, or conversations associated w/the trauma
 - 2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
 - 3. Inability to recall an important aspect of the traumas
 - 4. Markedly diminished interest or participation in significant activities

PTSD

- 5. Feeling of detachment or estrangement f/others
- 6. Restricted range of affect (unable to have loving feelings)
- 7. Sense of a foreshortened future (no expectation of a career, marriage/life partnership, children, normal life span)

PTSD

- D. Persistent sx of increased arousal as indicated by 2 or more of these:
 - 1. Difficulty falling or staying asleep
 - 2. Irritability or outbursts of anger
 - 3. Difficulty concentrating
 - 4. Hypervigilance
 - 5. Exaggerated startle response

PTSD

- E. Duration of the sx in B,C,D, is more than 1 month.
- F. Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of fx.

PTSD

- Acute: duration of sx less than 3 months
- Chronic: duration of sx 3 months or more
- With Delayed Onset: onset of sx is at least 6 months after stressor

PTSD Symptoms – simplified #1

- ***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.

PTSD Symptoms – simplified #2

- ***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
 - 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

PTSD Symptoms - Simplified #3

- ***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

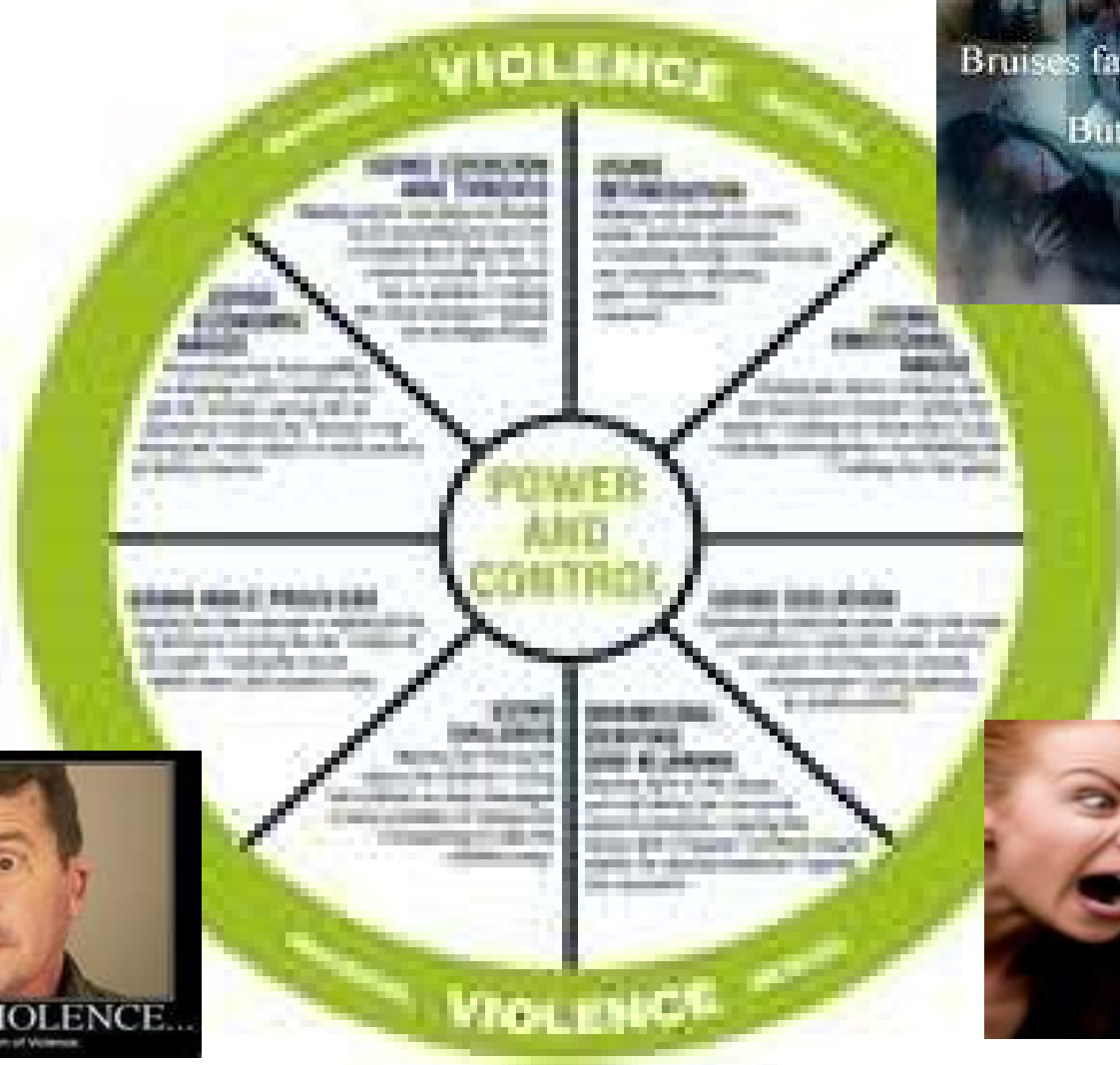
Note: Folks w/PTSD are at increased risk for suicide

Post-trauma, women with SUDs...

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

Connections between SUDs & DV/IPV

- 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 Mental Illness?

- 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

**PTSD does not go away
with abstinence...**

in fact, *IT OFTEN GETS WORSE!*

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

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 consumer
- Focus is on the *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 consumer?

OR

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

Traditional Tx Approach

- Deficit model; focus is on problems
- Single trauma event = single effect
- Expected and definable course of treatment & recovery
- 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 consumer is hierarchical (like whom??)
- PTSD is lens through which we view consumer
- Safety and trust in agency is a given & expected but not reciprocated

Trauma-Informed Services

- Consumer's worldview is due to trauma
 - Distrust, danger, confusion and self-blame are normal
- Sees how dealing with stresses of trauma causes 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 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 consumer using a Trauma-Informed Model
- 10 mins to briefly discuss
- Debrief in large group

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

**Coping with trauma
can feel like
walking through
fog....**

It's hard to tell
where you are
and what's
happening



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.”
- 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
- Consumers actively involved in all aspects of treatment planning and services
 - We are equal partners

New Integrated DV/IPV Services

- Safety guaranteed - not from other 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
 - *Consumer* becomes Change Agent – powerful!

We are never
healed from
trauma, simply
transformed....

The Phoenix



How do we develop & practice real Integrated Services?

It's possible but not easy - at first.

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

Feeling loved and supported

Can make all the difference in how you cope – or don't – with traumatic events in your life



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

Grounding

Experiencing *Grounding* (10min)



What can we do?

- Listen more than talk
- Gently help consumers link SUD & PTSD
- Discuss current - not past - problems
- 'Listen' to 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



← Way out

Exit to
street
only

Please stand
on the right



Hold the
handrail
Keep clear
of the edges

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/IPV, homelessness



Above all, be cautious – go slow

There is great danger in re-traumatizing consumers!

First, do no harm

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

--- Scott D. Miller

**We can help by
being a bridge...**

between the
old and the
new

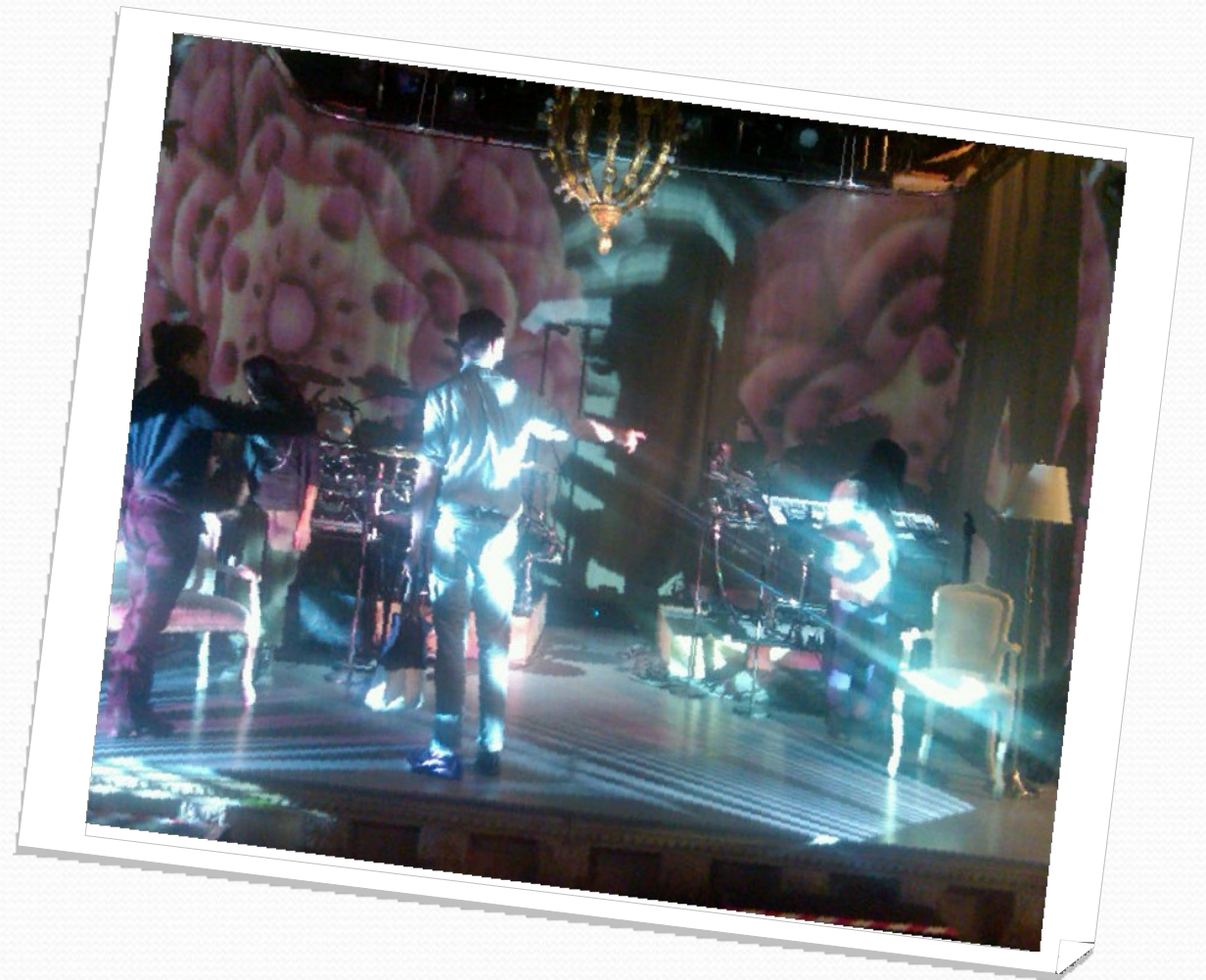


More we can do:

- Be willing to try new things; model healthy change for consumers (which means show them it's hard but do-able)
- Believe the 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 consumer's shoes
- Know we can't know everything – & be OK with that
- Have a great sense of humor!

Chaos can bring....

Innovation
and beauty



ACKNOWLEDGEMENTS

- *The Body Remembers: the Psychophysiology of Trauma & Trauma Treatment.* Babette Rothschild, 2000. WW Norton.
- *Trauma & Recovery.* Judith Herman, MD. 1992. Basic Books.
- *Many Roads, One Journey: Moving Beyond the 12-Steps.* Charlotte Kasl, Ph.D. 1992. HarperCollins.
- *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse.* Lisa Najavits, Ph.D. 2002. Guilford Press

For More Information...

- *Motivational Interviewing, (2nd Ed), Preparing People for Change.* William R. Miller & Stephen R. Rollnick, Guilford Press. 2002.
- *Waking the Tiger : Healing Trauma : The Innate Capacity to Transform O* by Peter Levine & Ann Frederick, 1997. North Atlantic Books.
- *Beyond Labels: Working with abuse survivors with mental illness symptoms or substance abuse issues.* Akers, et al. SafePlace, 2007.
www.safeplace.org.
- *Parenting in public.* Donna Haig Friedman & Rosa Clark. Columbia University Press, 2000.