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Psychological Trauma and Addiction Treatment

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SUMMARY. The interaction of psychological trauma and addiction has been noted for years, but only in the last decade has significant attention been focused on treating the two disorders concurrently. This chapter provides an overarching conceptual framework for understanding the nature of psychological trauma and its relationship to chemical dependency disorders and an introduction to the best thinking and practice in meeting the treatment needs of psychologically traumatized, chemically addicted people. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2006 by The Haworth Press, Inc. All rights reserved.]

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INTRODUCTION

Psychological trauma, in its broadest sense, is a wound to one's self, one's personhood. Trauma impacts how people perceive their worlds, their thoughts, judgments and intuition, what feelings they allow them-

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selves to have and what feelings they can't stop themselves from having. Perhaps most importantly, trauma impacts people's sense of who they are as unique individuals and their sense of soul—one's connection to something greater than the self. Trauma simultaneously causes hyperarousal and emotional constriction. The strategies people develop to contain and manage these trauma reactions can ultimately develop into a disorder of control—being out of control and trying to be in control.

The interaction of psychological trauma and addiction has been noted for years, but only in the last decade has significant attention been focused on treating the two disorders concurrently. This chapter provides an overarching conceptual framework for understanding the nature of psychological trauma and its relationship to chemical dependency disorders and an introduction to the best thinking and practice in meeting the treatment needs of psychologically traumatized, chemically addicted people.

THE NATURE OF PSYCHOLOGICAL TRAUMA

Traumatic events injure a person's dignity and sense of integrity. People often feel damaged, incomplete, and less human as a result of the experience. At the same time, trauma challenges and alters people's beliefs about the world, their potency, benevolence, significance and worthiness and damages their ability to trust themselves and the environment. As a result, traumatized people are often more guarded and less willing to venture out and take risks. Trauma also distorts people's sense of time and timing. Time becomes defined by traumatic events and therefore, people's judgment about when to act is impaired, leaving them to react impulsively or hesitantly. Judith Herman (1992) has described psychological trauma as a process of withdrawal and disconnection. In withdrawing from the world, traumatized people lose connection to that which is meaningful . . . family, community, spiritual life. In addition, trauma can impair people's ability to rejuvenate and recuperate and as a result, they are more susceptible to the debilitating effects of subsequent traumatic events.

Finally, traumatic events can overwhelm people's adaptive responses and their sense of control, connection, and meaning. When overwhelmed, people tend to engage in a defensive strategy of disconnection that protects them from further threat, whether actual or perceived (Herman, 1992). Paradoxically, this process of disconnection actually limits opportunities for recovery. Reconnection to self, others, community, the

environment, and a sense of that which is sacred is a key to full recovery. Recovery and treatment should focus on restoring connection in all areas where connection has been disrupted.

While psychological trauma is characterized by disruptions in a person's sense of control, addiction can also be viewed as a disorder of control, or more accurately, an inability to control. The loss of control is insidious, often unrecognized by the addict until, in Alcoholics Anonymous's terms, life becomes unmanageable. When a traumatized individual becomes addicted, or when an addicted person experiences trauma, the problem of control multiplies. People who are concurrently traumatized and addicted are particularly difficult to treat in traditional addiction settings where implicitly or explicitly clients are asked to give up control to the treatment program and other individuals. More often than not, the client ends up being blamed as uncooperative, not ready for treatment, obstructive or "in denial." Understanding the dynamic of control with people who are concurrently impacted by trauma and addiction is essential to successful treatment. The manifestations of this control dynamic along with approaches to treatment are clearly described by several authors in this text.

TRAUMATIC REACTIONS

Psychological trauma isn't the traumatic event itself. It is an experience characterized by an intense feeling of fear and helplessness. The traumatic event represents an outward manifestation of the inner experience of trauma. Trauma is sometimes described as "unspeakable," yet, traumatized people try to verbalize their inner experience by telling about the external events. The recollection of and retelling of the events become the vehicle by which traumatized people speak the unspeakable. The value of languaging one's experience, i.e., putting words to or naming it even though it cannot be fully described, is that it brings the inner experience into outward expression where it is possible to gain some perspective and place the traumatic events in the larger context of the totality of one's life.

Trauma reactions are truly individualistic. Some people may be significantly impaired by a relatively (in the eyes of others) inconsequential event, while other people move through devastating (in the eyes of others) events with little lasting impairment. As Peter Levine (1997) states, "It is important to remember that a traumatic reaction is valid regardless of how the event that induced it appears to anyone else" (pp.

49-50). Why some people are disabled by an event and others emerge relatively unscathed by the same or similar experience has to do with a person's resilience or ability to rebound, ego strengths, environmental supports, societal perceptions and timing. In diagnosis and treatment, then, it becomes important to understand the meaning of the event(s) to an individual and to address those meanings in the context of recovery.

While people can't change what has happened, the event, they can change their experience of the event. And that is what good trauma treatment does; it changes people's perception of what happened, who, if anyone, was at fault, what could have been done to prevent it, and, most important, what the experience means to that individual in the here and now.

A useful way of conceptualizing this process is to think about it from a relational perspective. We have a relationship with ourselves and a relationship with others; however, we also have a relationship to our own experiences. If I am engaged in a relationship with another person that is not satisfying or detrimental I cannot change the other person; however, I can explore the dysfunctional dynamics and work to change my own patterns of relating. The same is true regarding people's relationship to the traumatic events in their lives. We cannot change the traumatic event, but we can change our relationship to that experience. In this way it becomes possible to build mastery and enhance a felt sense of empowerment, both of which are disrupted by traumatic events, and thus mitigate some of the long-term psychological impact.

There are a number of aspects of this relational engagement with traumatic experiences that include cognitive/perceptual, sensate/physical, affective/emotional, and spiritual—that is, how we make meaning of our lives and place the meaning of trauma in the larger context of human experience. All of these aspects must be addressed in the treatment of psychological trauma.

THE IMPACT OF PSYCHOLOGICAL TRAUMA ON IDENTITY

Judith Herman (1992) also describes the multidimensional impact of trauma on identity. "Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim's faith

in a natural or divine order and cast the victim into a state of existential crisis” (p. 51).

The impact of trauma on identity depends, in part, on the age of the traumatized person, the chronicity of the events, and whether or not the trauma was of human origin. In the case of childhood trauma of human origin (e.g., sexual abuse, physical violence, or emotional abandonment or neglect) where the developing sense of self becomes organized around the breach of trust with the primary caretaker(s), there can be a terrible wounding to the child’s sense of dignity and integrity. The child may struggle with a pervasive sense of shame which shapes an identity of being “damaged goods.” In the case of chronic or single episodes of trauma of human origin in adulthood (e.g., domestic violence or rape), the individual’s identity may become organized around a pervasive sense of powerlessness, guilt, and inadequacy. In the case of traumatic events of nonhuman origin (e.g., natural disasters) or events of human origin on a large scale (e.g., war, terrorism attacks, the holocaust), the individual’s relationship to God or a sense of belonging to humanity may become altered and the impact on identity may take the shape of a spiritual crisis of faith and a disruption of worldview. The world may no longer be a safe place and faith no longer a safe harbor, where the individual can find comfort and make meaning of their suffering. Meaning and purpose may be lost and one’s spiritual identity damaged. It is important to remember that while it is during childhood where identity development is most important, trauma in adulthood can also have a tremendous impact on a person’s sense of integrity, trust, adequacy, and meaning. All of these disruptions to one’s relationship to self, others, one’s community, the world, and the divine must be addressed in treatment.

EXPERIENCING TRAUMATIC EVENTS

There are a number of variables which influence the way people experience traumatic events and thus, shape their relationship to those events. Some of those factors include the nature of the event itself, the reactions of others to the disclosure or witnessing of the traumatic event, the reaction of society, an individual’s previous history with trauma, pre-trauma coping styles, and resilience.

With regard to the nature of the traumatic event, the element of surprise where people have no time to fight or flee or prepare psychologically for the assault (e.g., World Trade Towers and Oklahoma City ter-

rorist attacks and the Tsunami in Indonesia) can increase a person's vulnerability to the effects of the trauma. The blindsiding nature of traumatic events also means that it is more difficult to recover from their effects. Trauma survivors will often say: "If I had only known what was going to happen" to describe this blindsiding experience. One response to being caught unaware or unprotected is to become hypervigilant: a primary trauma syndrome symptom. This hypervigilance or hyperarousal then activates secondary effects such as misinterpretation of environmental stimuli, an inability to "let down" emotional armor, and overreaction to the perception of internal and external threats. In short, trauma exhausts the traumatized, and causes them to be unduly vigilant, suspicious and mistrustful. Research has shown that when it is possible to prepare for a stressful event, preparation increases a person's sense of control and actually helps train the autonomic system to respond more effectively to the stressor (Shalev, 1996), thus mitigating hyperarousal and hypervigilance.

In addition, the threat of death or violation of bodily integrity through violence (e.g., child sexual abuse or rape), the incomprehensible brutality of the abuser (e.g., torture), the frequency, repetition, chronicity of the events (e.g., ongoing child abuse), and a negative response toward the traumatized person by family (e.g., adults do not believe a child's disclosure of sexual abuse) or the culture (e.g., blaming the rape victim for being vulnerable to assault) all contribute to an increase in the severity of the impact on the traumatized person. You will often hear adult survivors of childhood abuse describe the reactions of family members to their disclosure as more traumatic than the events themselves. One adult survivor, a recovering alcoholic, talked about her experience of testifying in court at the age of eight against her uncle who had fondled her. She became overwhelmed with shame when the adults in the courtroom, including some family members, laughed at her child's way of describing his body. She reported that this courtroom experience was much more traumatic for her than her uncle's touch. The elements of the traumatic events described above represent risks to the individual in developing both psychological trauma symptoms and addiction problems.

In addition to the nature of the traumatic event itself, how others in the traumatized person's life and the society as a whole respond to trauma can have either a detrimental or ameliorating impact on how the traumatized person experiences the traumatic event, makes meaning of it, and negotiates the emotionally hazardous landscape of his/her relationship to the trauma. Because traumatic events create disconnections

in relationships, the people closest to the traumatized person can lessen that experience of disconnection (and thereby ameliorate the influence of the traumatic events on a person's identity, meaning, and worldview) by responding in a supportive way, offering hope, comfort, a sense of safety, acceptance and compassion, and by helping the traumatized person realize that his/her reactions to the traumatic event are normal, not a personal failure. It is essential that the clinician provide a context in therapy within which the traumatized person can feel safe enough to be vulnerable, rebuild connection, and repair damage to his/her sense of self.

The hard work of rebuilding connection, unfortunately, must be done in a societal context that all too often blames victims for their vulnerability. Society also shuns victims because it does not want to believe that events like child abuse, incest, abandonment and rape happen and places too much emphasis on personal responsibility without considering the social context which shapes traumatized people's lives and identities. A recent example of this occurred in the aftermath of the devastating hurricanes on the Gulf Coast. While there were efforts to evacuate many people from the city of New Orleans, for example, and some chose to stay in their homes who could have left, there were many thousands of people living in poverty who had no means of evacuating. Some of the initial reactions to those stranded in their homes included blaming them for their own plight. "People had plenty of warning. They should have left." There was little consideration from some sectors of society for the trauma of poverty itself nor a willingness to accept some responsibility for the conditions of poverty which had a direct and negative impact on people's ability to prepare for, respond to, and recover from these natural disasters. The impact on those who are blamed for their own victimization is often a pervasive sense of being invisible and devalued.

Some of the psychological variables that impact how a person experiences and reacts or responds to traumatic events include a previous history of psychological trauma, the ability to make meaning of the events and integrate that meaning into a person's schema, the ability to negotiate emotional reactions to trauma, and pre-trauma coping skills and resilience. A previous history of unresolved trauma will make it more difficult for a person to negotiate the experience of current trauma. By nature of their developmental status, children lack the cognitive, emotional, physical, and spiritual (or meaning-making) skills necessary to cope with overwhelming experiences. This is why it is so important for children who have experienced traumatic events to receive adult help and support immediately. When this support is lacking or the adults in a

child's life are the source of the trauma the child will develop his/her own strategies for coping that can include rigid ego defenses, compulsive behaviors which may be a precursor to addictive disorders, limited affective responsiveness, and a chronic sense of over-responsibility, guilt, and shame. While these strategies are essentially creative survival tools for a child, they may inhibit a child's psychological and emotional development and his/her ability later in life to have a fulfilling relational life.

Resilience is the most important psychological factor that can mitigate the negative long-term impact of traumatic events. It helps people develop and maintain a different relationship to their traumatic experiences. It differentiates people who are debilitated by traumatic events and those who are able to minimize the negative impact on their sense of self, their relationships, and their lives. Gina O'Connell Higgins (1994) defines psychological resilience as an active process of self-righting and growth that includes an ability to negotiate "emotionally hazardous experiences proactively rather than reactively" (p. 20) and an ability to make positive meanings out of experience. Higgins (1994) describes resilient people as those who demonstrate strong ego development and empathetic attunement, and possess internal resources such as creativity, imagination, an ability to envision a different future in spite of a traumatic past, and an ability to recruit and receive support from others (e.g., the abused child who seeks out "surrogate parents" in the form of a friend's parents, teachers, coaches, etc.). As noted later in this volume (Burke, 2006), resilience can act to buffer the stress reaction in traumatized people and that a strong sense of spirituality not only enhances and promotes resilience, but can prevent substance abuse and enhance long term recovery. Therefore, one of the most important aspects of the integrated treatment of psychological trauma and addictions may be to support traumatized people to explore their spirituality as a resource in recovery and help them discover and enhance those internal resources that describe resilience.

RECOGNIZING TRAUMA SYNDROMES

There is little consensus on how much trauma, how much impairment one must have before being diagnosed with a trauma syndrome. Many people with trauma syndromes are diagnosed with other psychiatric illnesses, such as depression and anxiety reactions. Often the manifestations of trauma syndromes are hidden behind substance abuse and other

addictive behaviors. Finally, people with primary psychiatric disorders may assume their symptoms are a result of a trauma experience, when in fact, they are the result of another psychiatric illness. As a result, the science of trauma syndrome diagnosis is inexact and could benefit from further development.

The two most common DSM IV diagnoses used for trauma disorders are Acute Stress Reaction and Post Traumatic Stress Disorder. Both of these disorders are addressed in some detail in later chapters. But we also know that many people, severely limited by their trauma experiences, aren't necessarily a good "fit" for these diagnoses. Judith Herman (1992) used the term "Complex Post Traumatic Stress Disorder" to describe individuals for whom the trauma experience resulted in profound depersonalization. Individuals with profound and seemingly unresolvable grief become intrapsychically and interpersonally limited by their irascibility, perfectionism, obsessiveness, inappropriate interpersonal interactions and obsessiveness, but don't meet the standards for conventional psychiatric diagnoses.

Finally, many people with cumulative developmental trauma such as parental addiction, mental illness or incarceration, chronic physical illness or death of parent(s) certainly have residual impacts from the experience that limit options in adult life. Sometimes the trauma is more subtle, when a parent is consistently emotionally absent, too emotionally immature or too absorbed with their own dilemmas to experience and address the emotional needs of the child. Even when parents are emotionally attuned and available, dynamics such as pervasive poverty, a childhood physical disfigurement, an exceptionally rigid, chaotic or brutal subculture, familial or extrafamilial sexual abuse or other dynamics can cause the child to take a limiting psychoemotional adaptive life stance. Such life circumstances have a powerful impact on development of core psychological attributes such as hope, trust, competency, potency, integrity, self-soothing and empathy as well as limiting an individual's psychological development, self-esteem, attachment styles and psychosocial and interpersonal skills. While many people are significantly impacted by childhood adversities, it is the adaptive stance taken to manage the emotional and psychological response to overwhelming adversity that becomes, in adulthood, a limiting and defining part of personality. Some of the adaptations or coping strategies often seen include addiction, psychiatric symptomatology, overachieving and underachieving, lack of depth in relationships, compulsive behaviors and emotional rigidity. A hallmark of the limiting adaptive stance is that an individual can be highly successful in some arenas of life while being

significantly impaired in others. This hallmark often differentiates people with limiting life resources from people with significant personality disorders.

TREATMENT APPROACHES

To the extent that psychological trauma has historically been addressed in addiction treatment settings, it has been relegated to a “wait until later” status. This approach has been congruent with a larger effort to prioritize treatment goals, beginning with preparing/mobilizing an individual for treatment, then building a foundation of abstinence and control of problem behaviors, then building strengths in sobriety and finally, working on “peripheral” issues such as marriage and other familial dynamics, psychological trauma, mental health, occupational issues and spiritual growth. Researchers and writers in the “dual diagnosis” movement of the late 1990s came to term this approach a “sequential pattern” of treatment (Mueser, Noordsy, Drake and Fox, 2003). Two findings began to challenge the assumptions underlying sequential treatment. First, particularly with the advent of interest in individuals with dual diagnoses, it became apparent that some people could not build a platform of abstinence, maintain control over problem behaviors and develop significant psychological strengths in recovery without concurrently addressing mental health and psychological trauma dynamics. Secondly, as efforts were initiated to address these issues earlier in the recovery process, it was learned that not only did clients not regress or fail in treatment, but they actually benefitted from earlier interventions. In short, researchers and clinicians began to challenge assumptions about the capabilities (or lack thereof) of clients to handle these issues earlier in recovery and concomitantly maintain sobriety.

Mueser, Noordsy, Drake and Fox (2003) cited additional problems with sequential treatment, including a recognition that the untreated disorder often worsens the treated disorder, making it impossible to stabilize one disorder without attending to the other and secondly, that it is more often than not unclear when one disorder has been successfully treated so that treatment of the other disorder can commence. As a result, one disorder goes untreated.

Still, even with the recognition that clients could benefit from earlier intervention for mental health and psychological trauma disorders, two problems appeared. First, addiction treatment has historically been pro-

vided in a distinct and separate treatment environment from mental health and psychological trauma services. As a result, clients had to enter multiple treatment programs designed to treat specific problems. Secondly, a pool of adequately trained and supervised clinicians did not exist who could treat multi-problem/dual-diagnosed people. As a result, multi-problem people had to have multiple therapists and counselors. From this dilemma grew a pattern of “parallel treatment,” in effect, treating separate problems at the same time, but in different settings and/or with different counselors. There are obvious disadvantages of such an approach. Mueser, Noordsy, Drake and Fox (2003) point out: (1) that treatment providers and agencies often fail to communicate with each other; (2) that the burden of integrating treatment falls on the client; (3) that funding and eligibility barriers in accessing both treatments exist; (4) that different treatment providers and agencies may have differing and conflicting philosophies; (5) that no agency has “final accountability” for the client’s progress and recovery.

An increasing recognition of the need for a treatment protocol that integrates services designed to meet specific client needs has emerged from the research. Nowhere is this need more apparent than for people with co-occurring addiction and psychological trauma disorders. As a result, two patterns have evolved. The first is an increasing recognition of the need for providers to be “cross-trained.” The second is the recognition that new treatment models need to be developed that recognize and appreciate the needs of individuals with both disorders. Najavits (2002) in her “Seeking Safety” program clearly addresses both of these concerns.

Some of the other concerns in integrated treatment, addressed by Mueser, Noordsy, Drake and Fox (2003), include integration of services, a long term perspective and time unlimited services, shared decision making on the part of providers and the client, the need to offer a comprehensive range of services and assertiveness in outreach and client management. While their work is focused on the larger issue of mental health disorders and addiction, most of their concerns are equally appropriate for treating co-morbid trauma and addiction disorders.

In summary, the advantages of an integrated treatment approach greatly outweigh any disadvantages. The reasons for not implementing an integrated treatment approach are more often a function of funding, a history of segregated, “problem specific” treatment and limitations of understanding both disorders on the part of counselors and therapists.

This collection makes a reasoned and coherent argument for integrated treatment.

WHO IS QUALIFIED TO TREAT CHEMICALLY DEPENDENT TRAUMATIZED PEOPLE?

It is unreasonable to expect that all individuals who staff chemical dependency treatment environments should be proficient in treating trauma disorders. Likewise, it is unreasonable to expect that all people competent in treating trauma disorders are sufficiently well versed, trained and have the agency resources to treat chemical dependency. At a minimum, however, all counselors and therapists should have a working knowledge of the problems faced by addicted, traumatized clients and an awareness of the resources necessary to address both problems. If counselors have this working knowledge, some trauma treatments, for instance, Najavits, manualized “Seeking Safety” model, can be implemented with minimal training and ongoing clinical supervision.

What is needed in both substance abuse and mental health treatment domains is a broad base of clinicians who are able to recognize individuals with co-occurring psychological trauma and chemical dependency disorders, a somewhat smaller group of clinicians who can, with supervision, conduct basic treatment protocols and a still smaller group who are highly knowledgeable and skilled in providing advanced treatment and are sufficiently trained to supervise other staff in the provision of services to individuals with co-occurring disorders.

The ability of chemical dependency treatment clinicians to understand the impact of psychological trauma on chemically dependent people, how that impact manifests as symptoms, how trauma symptoms appear as behavioral patterns and how those patterns might be significant impediments to chemical dependency treatment should be basic knowledge for all chemical dependency counselors. Concomitantly, because of the close relationship between trauma and chemical dependency, anyone who works with traumatized people should be aware of the basic symptoms of addictive disorders, should understand how an active addictive disorder might manifest in individuals with diagnosed trauma syndromes and should appreciate that both disorders have to be treated concurrently for the affected individual to have a reasonable chance of recovery. Additionally, staff of treatment programs for both groups

should have a working knowledge of diagnostic and treatment resources for both disorders and should be able to provide basic client education about both disorders.

To provide adequate concurrent or integrated treatment of individuals with co-occurring trauma and addictive disorders, there needs to be a body of clinicians who not only are *trauma and addiction disorder aware*, but are also *trained and informed* in core treatment methods. Trauma and addiction informed counselors should be prepared to help clients recognize and accept diagnoses of trauma and addiction disorders, should help clients build safety with trauma symptoms and the exposure of those symptoms, should be capable of treating, under supervision, acute stress disorders and grief reactions, and with supervision, conduct structured manualized treatment protocols for traumatized people in addiction treatment settings. Likewise, trained and informed counselors should be able to help clients recognize and accept symptoms of addictive illnesses, help those clients mobilize to enter treatment and be able to provide, under supervision, basic addiction treatment services.

A third group of clinicians necessary for quality concurrent or integrated treatment might be termed *trauma and addiction treatment competent*. This group of clinicians should have advanced training in treatment of difficult cases, should have advanced skills in specific approaches and methodologies for treatment of co-occurring trauma and addiction, and, perhaps most importantly, should have skills in team leadership and supervision to provide direction and consultation to counselors. While it might not be reasonable to expect that every addiction or trauma treatment program could have such a clinician, it seems perfectly reasonable that such a clinician can be employed part-time or in a consultant capacity. Without such an individual in the treatment team, it is doubtful a treatment program can maintain the focus, direction and success necessary for quality treatment of people with co-occurring disorders.

CONCLUSION

Significant changes have occurred in the last decade in the recognition of the co-occurrence of psychological trauma and substance abuse. There is now considerable agreement that the best treatment is to confront both disorders concurrently in early addiction recovery with an integrated treatment staff that is emotionally responsive and technically

proficient to address the total needs of the client. There is also a greater appreciation for the impact of trauma on quality of life when the trauma syndrome manifests later in recovery. There is widening appreciation for the scope of trauma disorders beyond PTSD and Acute Stress Reactions and how those other trauma disorders manifest in substance abusing clients. There is an increasing armament of resources and methodologies including manualized treatment, use of EMDR, Affect Regulation Therapy and experiential therapies to complement the growing body of knowledge in the more conventional realms of psychodynamic therapy, the cognitive therapies and the 12-Step recovery movement. There is an increasing awareness of the special needs of women in treatment, of the roles of spirituality and forgiveness in recovery and the impact of psycho-neurology on the treatment process. This book represents a concerted effort to bring together current thinking, best practices, and supportive resources in furtherance of an integrated approach to the treatment of psychological trauma and addiction.

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