Trauma and Substance Use

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What is trauma?

The word “trauma” is used to describe experiences or situations:

- That are emotionally painful and distressing
- That overwhelm people’s ability to cope
- That leave them feeling powerless.
Prevalence of Trauma in Addiction Treatment

- Estimated rates are from 25% to 95% of all patients entering addiction treatment
- Estimated rates of PTSD are approximately 25% of patients entering mental health treatment (of which 2/3 have substance use)
  - Rates are higher among women, opiate and cocaine dependent individuals
- Rates have been found to be higher among whites and African-Americans (vs. Hispanic and Asian-Americans)
Prevalence of PTSD in Addiction Treatment

- Many clients with substance use disorders have experienced a trauma, but only 25% of trauma victims will develop PTSD.
- The trauma will usually produce symptoms even if full criteria for PTSD is not met.
- Trauma may precede substance use disorder, occur during, or both.
- For many people who develop full criteria for PTSD, trauma was often just a singular event, but was a repetitive pattern.
Gender differences

- For **women**, the most common events were rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse.

- **Women** not only experience a greater number of PTSD symptoms than men, but they also experience them more frequently and for longer durations.
Gender differences

The traumatic events most often associated with PTSD in men were rape, combat exposure, childhood neglect, and childhood physical abuse.
Simple vs. Complex PTSD

- **Simple PTSD** typically develops from one incident, usually experienced as an adult.

- **Complex PTSD** is associated with repeated incidents (domestic violence or ongoing childhood abuse).
  - Broader range of symptoms: self-harm, suicide, dissociation (losing time, numbing); problems with relationships, memory, sexuality, health, anger, shame, guilt, numbness, loss of faith and trust, feeling damaged.
Features of “Complex PTSD
A complex of symptoms associated with early interpersonal trauma

- Alterations in
  - the regulation of affective impulses (e.g., difficulty with modulation of anger and being self destructive)
  - attention and consciousness leading to amnesias, dissociative episodes, and depersonalization
  - self-perception (e.g., chronic sense of guilt and shame)
  - interpersonal relationships (e.g., not being able to trust, not being able to feel intimate with people)
  - somatization
  - systems of meaning
Prevalence of Childhood Sexual Abuse

In the Community
In Tx for Mental Illness
In Substance Abuse
HIV+

Women
Men
The ACE Study – probably one of the most important public health studies you’ve never heard of – had its origins in an obesity clinic on a quiet street in San Diego.

50-percent dropout rate in the obesity clinic that Felitti started in 1980.

Why would people who were 300 pounds overweight lose 100 pounds, and then drop out when they were on a roll?
He decided to dig deep into the dropouts’ medical records.

This revealed a couple of surprises:

- All the dropouts had been born at a normal weight.
- They didn’t gain weight slowly over several years.
Most of the participants had been sexually abused as children.
Most had started gaining weight as a result of the abuse and gained it very quickly.
Eating soothed their anxiety, fear, anger or depression – it worked like alcohol or tobacco or methamphetamines.
Not eating increased their anxiety, depression, and fear to levels that were intolerable.
Adverse Childhood Events (ACE) Study

- These findings led to a mega study by the CDC.
- It would provide more understanding about the lives of hundreds of millions of people around the world who use biochemical coping methods – such as alcohol, marijuana, food, sex, tobacco, violence, work, methamphetamines, thrill sports – to escape intense fear, anxiety, depression, anger.
Adverse Childhood Events (ACE) Study

- Kaiser/Permanente and the CDC
- Large-scale epidemiological study of the influence of stressful and traumatic childhood experiences
- Interviewed over 17,000 people
- Motivated by an obesity study

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Adverse Childhood Events (ACE) Study

- About two-thirds of the adults in the study had experienced one or more types of adverse childhood experiences.
- Of those, 87 percent had experienced 2 or more types.
- For example, it showed that people who had an alcoholic father were likely to have also experienced physical abuse or verbal abuse.
- In other words, ACEs usually didn’t happen in isolation.
Adverse Childhood Events (ACE) Study

Demographic Information
- Female 54.0% Male 46.0%

Race/Ethnicity
- White-74.8%, Hispanic/Latino-11.2%, Asian/Pacific Islander-7.2%, African-American-4.5%, Other 2.3%

Age (years)
- 19-29 5.3%, 30-39 9.8% 40-49, 18.6%
- 50-59 19.9% 60 and over 46.4%

Education
- Not High School Graduate 7.2%
- High School Graduate 17.6%
- Some College 35.9%
- College Graduate or Higher 39.3%
Questions in the ACE Study

All ACE questions refer to the respondent's first 18 years of life:

- Abuse
- Household Challenges
- Neglect
Questions in the ACE Study

Abuse

- **Emotional abuse:** A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.

- **Physical abuse:** A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.

- **Sexual abuse:** An adult, relative, family friend, or stranger who was at least 5 years older than you ever touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, attempted to have any type of sexual intercourse with you.
Questions in the ACE Study

Household Challenges

- **Mother treated violently:** Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother’s boyfriend.

- **Household substance abuse:** A household member was a problem drinker or alcoholic or a household member used street drugs.

- **Mental illness in household:** A household member was depressed or mentally ill or a household member attempted suicide.

- **Parental separation or divorce:** Your parents were ever separated or divorced.

- **Criminal household member:** A household member went to prison.
Questions in the ACE Study

Neglect

- **Emotional neglect**: Someone in your family helped you feel important or special, you felt loved, people in your family looked out for each other and felt close to each other, and your family was a source of strength and support.

- **Physical neglect**: There was someone to take care of you, protect you, and take you to the doctor if you needed it, you didn’t have enough to eat, your parents were too drunk or too high to take care of you, and you had to wear dirty clothes
Adverse Childhood Experiences (ACEs)

- 11% experienced emotional abuse.
- 28% experienced physical abuse.
- 21% experienced sexual abuse.
- 15% experienced emotional neglect.
- 10% experienced physical neglect.
- 13% witnessed their mothers being treated violently.
- 27% grew up with someone in the household using alcohol and/or drugs.
- 19% grew up with a mentally-ill person in the household.
- 23% lost a parent due to separation or divorce.
- 5% grew up with a household member in jail or prison.
Adverse Childhood Experiences (ACEs)

- They were twice as likely to be smokers,
- 12 times more likely to have attempted suicide,
- 7 times more likely to be alcoholic, and
- 10 times more likely to have injected street drugs.

People with high ACE scores are more likely to be violent, to have more marriages, more broken bones, more drug prescriptions, more depression, more auto-immune diseases, and more work absences.
Trauma and Physical Health

Particularly chronic sexual and physical abuse in childhood affect adult rates

- Heart disease
- Cancer
- Gastrointestinal disorders
- Chronic pain

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Clinically significant symptoms:

- The abuse occurred at a younger age
- Persisted over a longer period of time
- Involved several individuals

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Adverse Childhood Experiences (ACEs)

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease
- Liver disease
- Poor work performance
- Financial stress
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy
- Risk for sexual violence
- Poor academic achievement
Cognitive and neuroscience researchers have examined possible mechanisms that might explain the negative consequences of adverse childhood experiences on adult health.

Adverse childhood experiences can alter the structural of neural developmental networks and the biochemistry of neuroendocrine systems and may have long-term effects on the body, including speeding up the processes of disease and aging and compromising immune systems.

Additionally, epigenetic transmission may occur due to stress during pregnancy or during interactions between mother and newborns. Maternal stress, depression, and exposure to partner violence have all been shown to have epigenetic effects on infants.
Other Studies

- Other clinical studies found that patients with higher levels of childhood trauma have higher rates of PTSD, substance dependence, especially alcohol, cocaine, and cannabis, and are more likely to report injecting drugs (Khoury, Tang, Bradley, Cubells, & Ressler, 2010; Wu, Schairer, Dellor, & Grella, 2010).

- Women who report having been raped report higher levels of PTSD, major depression, and alcohol abuse compared to others with child-victimization histories but who have not been raped.

- Women in a residential treatment facility-95% had experienced some type of trauma, and 75% still met full criteria for PTSD.
Risk Factors

A combination of individual, relational, community, and societal factors contribute to the risk of child abuse and neglect. Risk factors are those characteristics associated with child abuse and neglect—they may or may not be direct causes.
Risk Factors for Victimization

Individual Risk Factors

- Children younger than 4 years of age
- Special needs that may increase caregiver burden (e.g., disabilities, mental retardation, mental health issues, and chronic physical illnesses)
Risk Factors for Victimization

Family Risk Factors

- Parents' lack of understanding of children's needs, child development and parenting skills
- Parents' history of child maltreatment in family of origin
- Substance abuse and/or mental health issues including depression in the family
- Parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income
- Non-biological, transient caregivers in the home (e.g., mother’s male partner)
Risk Factors for Victimization

Family Risk Factors

- Social isolation
- Family disorganization, dissolution, and violence, including intimate partner violence
- Parenting stress, poor parent-child relationships, and negative interactions
- Parental thoughts and emotions that tend to support or justify maltreatment behaviors
Community Risk Factors

- Community violence
- Concentrated neighborhood disadvantage (e.g., high poverty and residential instability, high unemployment rates, and high density of alcohol outlets), and poor social connections.
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Family Protective Factors

- Nurturing parenting skills
- Stable family relationships
- Household rules and child monitoring
- Parental employment
- Adequate housing
- Access to health care and social services
- Caring adults outside the family who can serve as role models or mentors
What **can** Be Done About ACES?

These wide-ranging health and social consequences underscore the importance of preventing ACEs before they happen. **Safe, stable, and nurturing relationships and environments** (SSNREs) can have a positive impact on a broad range of health problems and on the development of skills that will help children reach their full potential. Strategies that address the needs of children and their families include:

- Voluntary home visiting programs can help families by strengthening maternal parenting practices, the quality of the child's home environment, and children's development. **Example: Nurse-Family Partnership**
  - Home visiting to pregnant women and families with newborns
  - Parenting training programs
  - Intimate partner violence prevention
  - Social support for parents

- Parent support programs for teens and teen pregnancy prevention programs
- Mental illness and substance abuse treatment
- High quality child care
- Sufficient income support for lower income families
Clinical Challenges in the Treatment of Traumatic Stress and Addiction

- Abstinence may not resolve comorbid trauma-related disorders
  - for many patients the PTSD worsens
- Women with PTSD abuse the most severe substances and are vulnerable to relapse for both conditions, as well as repeated trauma
- Confrontational approaches typical in addictions settings frequently exacerbate mood and anxiety disorders
- 12-Step Models often do not acknowledge the need for pharmacologic interventions
- Treatment programs often do not offer integrated treatments for Substance Use and PTSD
- Treatments for only one disorder, such as Exposure-Based Approaches, are often marked by complications
  - treatments developed for PTSD alone may not be advisable to treat women with addictions
PTSD and Substance Use Disorders: Negative Outcomes

- More severe PTSD
- More addictive drugs (opiates, cocaine)
- Recurrent victimization and trauma (including domestic violence)
- Shorter periods of abstinence, more frequent relapse
- More severe psychiatric problems/symptoms
- More problems in functioning: Legal, medical, work, & relationships
- Poorer treatment and peer support group benefits
Treatment

- Address basics needs
- Create trauma informed systems
- Evidenced based treatment
- Stages of Healing and treatment
- Know Principles of Co-occurring treatment
Address Basic Needs First

- Basic Needs
- Safety Needs
- Social Needs
- Esteem Needs
- Self-Actualization
According to SAMHSA’s concept of a trauma-informed approach, “A program, organization, or system that is trauma-informed:

- **Realizes** the widespread impact of trauma and understands potential paths for recovery;
- **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices; and
- **Seeks** to actively resist *re-traumatization.*
SAMHSA’s Six Key Principles of a Trauma-Informed Approach

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures:

- Safety
- Trustworthiness and Transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice and choice
- Cultural, Historical, and Gender Issues
Evidence-based Practices for PTSD

- The most efficacious psychosocial treatment is a behavioral therapy: Exposure Therapy (Foa & Rothbaum, 2000).
- Exposure therapy yields robust outcomes in most populations, but:
  1) Has excluded persons with addictive disorders;
  2) Has high drop-out rates (75%); and
  3) Is believed to be too stressful for many patients
Stages of Healing and Treatment

1. **SAFETY:** This is the phase you are in now. The goals are to free yourself from substance abuse, stay alive, build healthy relationships, gain control over your feelings, learn to cope with day-to-day problems, protect yourself from destructive people and situations, not hurt yourself or others, increase your functioning, and attain stability. - **Here and Now focus**

2. **MOURNING:** Once you are more safe, you may need to grieve about the past, about what your trauma and substance abuse did to you. You may need to cry deeply to get over the losses and pain you experienced: loss of innocence, loss of trust, loss of time - **Past focus**

3. **RECONNECTION:** After letting yourself experience mourning, you will find yourself more willing and able to reconnect with the world in joyful ways: thriving, enjoying life, able to work and relate well to others. You will get to this stage if you can establish safety now. **Future Focus**

Adapted from Herman, Trauma and Recovery, 1992
Seeking Safety---Lisa Najavits, Ph.D.
Harvard Medical School, www.seekingsafety.org

- Developed as a group treatment for PTSD/SUD women
- Based on CBT models of SUDs, PTSD treatment, women’s treatment, and educational research
- Educates patients about PTSD and SUDs and the interaction of the two disorders
- Goals include abstinence and decreased PTSD symptoms
- Focuses on enhancing coping skills, safety, and self-care
- Active, structured treatment - therapist teaches, supports and encourages
- Case management
Dialectical Behavior Therapy (DBT)

The DBT model incorporates skill training in a variety of areas such as:
- Mindfulness - Focus on the here and now
- Interpersonal effectiveness,
- Emotion regulation
- Distress tolerance
- Skills based program that addressed the “here and now” issues of the client
Principles of Co-occurring Treatment

1. Dual Diagnosis is an *expectation*, not an *exception*
Principles of Co-occurring Treatment

2. When substance disorder and psychiatric disorder co-exist, each disorder should be considered primary, and integrated dual primary treatment is recommended, where each disorder receives appropriately intensive diagnosis-specific treatment.
Principles of Co-occurring Treatment

3. Employ a recovery perspective. Both substance dependence and serious mental illness are examples of primary, chronic, biologic mental illnesses, which can be understood using a disease and recovery model.
4. There is no one type of dual diagnosis program or intervention. Adopt a multi-problem and treatment viewpoint. For each person, the correct treatment intervention must be individualized according to subtype of dual disorder, and diagnosis, phase of recovery, stage of treatment, level of functioning, skills, and/or disability, plus goals, problems, and contingencies, associated with each disorder.
Principles of Co-occurring Treatment

5. Develop a phased approach to treatment.
## STAGES OF TREATMENT

### ENGAGEMENT

1. Pre-engagement
2. Engagement

Goals: Build Rapport, Establish Trust, find out what is important to client, Meet immediate needs Stabilize client

### PERSUASION

3. Early Persuasion
4. Late Persuasion

Goals: Identify Triggers, Assess current coping skill, introduce new coping skills, Begin to develop Relapse Plan, educate client, begin building other supports

### ACTIVE TREATMENT

5. Early Active Rx
6. Late Active Rx

Goals: Develop a complete written plan, encourage client in practicing plan, increase social supports.

### RELAPSE PREVENTION

7. Relapse Prevention
8. Remission

Goals: Identify Relapse and associated problems, Re-establish self-efficacy, Help client view as learning moment, Develop new behavioral strategies, Review coping skills Review and make changes in relapse plan
Principles of Co-occurring Treatment

7. Plan for the client’s cognitive and functional impairments.
Principles of Co-occurring Treatment

8. Use support systems to maintain and extend treatment effectiveness
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