TRAUMA RESOLUTION IS RELAPSE PREVENTION

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PRESENTER: SUSIE KOWALSKY, LCPC

EMAIL: PRACTICEFORPROGRESSINC@GMAIL.COM

WEBSITE: WWW.PRACTICEFORPROGRESS.COM
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OBJECTIVES

- Explore the intersection of traumatic events and substance use disorders.
- Identify trauma-informed principles for meeting co-occurring needs.
- Cultivate innovative and integrated approaches to recovery from traumatic events and substance use disorders.
TRAUMA AND SUBSTANCE USE DISORDERS

- Share a lot of common ground
- Interact with each other
- Must understand the influence of trauma to be effective in treating substance use disorders
What percentage of the people in your program have experienced trauma?

A. Less than 25%
B. 25-50%
C. 50-75%
D. More than 75%
E. I’m not sure

* Please enter your response in the poll *
COMPLEX TRAUMA AND SUBSTANCE USE

- Teens with history of physical or sexual abuse = 3x rate of current or past substance use
- 59% of adolescents with PTSD develop substance use problems.
- 70% of adolescents in substance use treatment had history of trauma exposure
- Substance use as a coping strategy for complex trauma

**SUBSTANCE USE AND TRAUMA**

<table>
<thead>
<tr>
<th>Increase</th>
<th>Alter</th>
<th>Inhibit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance use can increase engagement in risky behaviors</td>
<td>Substance use can alter ability to discern safety from danger</td>
<td>Severe substance use can inhibit ability to cope with traumatic events</td>
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</tbody>
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Risky behaviors are initially adaptive

Trauma impacts people’s ability to think through long term consequences of behaviors or to make future plans/goals

Dissociation can numb people’s experiences, requiring increasing levels of risk

Examples: substance use, self-injurious behaviors, gambling, shoplifting, aggression, and violence (gang activity)
DISCERNING DANGER & SAFETY

- Alarm fatigue
- Distorted sense of safety
  - Feel safe when in danger
  - Feel in danger when safe
- Increased likelihood of re-traumatization
Shame and stigma about trauma/risky behaviors makes people hesitant to talk about them.

Trauma often occurs within context of relationships.

De-personalization and de-realization contribute to isolation.

Less likely to engage with service providers.

Less likely to have social supports.

More likely to use substances alone.
Substance use can increase risk of trauma

Substance use to manage trauma

Substance use to manage trauma
CHALLENGES IN TREATING COMPLEX TRAUMA AND SUBSTANCE USE DISORDER

- Abstinence may not resolve comorbid trauma-related symptoms or disorders; for some, trauma symptoms may worsen.

- Confrontational approaches can exacerbate mood and anxiety disorders and disempower individuals.

- 12-Step Models may not acknowledge the value of pharmacologic interventions, the impact of trauma, and carry shame-based messages.

- Treatments for PTSD only, such as Exposure-Based Approaches, may not be effective in addressing substance use.
A program, organization, or system that:

- 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
- Seeks to actively resist re-traumatization
POSTTRAUMATIC STRESS DISORDER IN DSM-5

- Traumatic event, followed by:
  - Re-experiencing
    - Flashbacks, nightmares, involuntary memories
  - Avoidance
    - Avoid thoughts, feelings, people, places, things associated with event; dissociation
  - Negative change in mood and thoughts
    - Exaggerated negatives beliefs about self/others, feelings of guilt/shame, feelings of detachment
  - Change in arousal and reactivity
    - Hypervigilance, aggressive outbursts, exaggerated startle response
- Lasts more than 1 month
- Disrupts functioning
Re-enactment
Recreating the childhood dynamic expecting the same result but hoping for a different one. This strategy is doomed to failure because the need is in the past and cannot be resolved. Also you will interpret anything as confirmation that you have been betrayed once more.

Loss of self-worth
Trauma survivors can swing between feeling special, with grandiose beliefs about themselves, and feeling dirty and ‘bad.’ This self-aggrandizement is an elaborate defense against the unbearable feeling of being an outcast and unworthy of love.

Loss of sense of self
One of the roles of the primary caregiver is to help us discover our identity by reflecting who we are back at us. If the abuser was a parent or caregiver, then that sense of self is not well developed and can leave us feeling phony or fake.

Loss of physical connection to body
Survivors of sexual and physical abuse often have a hard time being in their body. This disconnection from the body makes some therapies know to aid trauma recovery, such as yoga, harder for these survivors.

Dissociation
Often, to cope with what is happening to the body during the abuse, the child will dissociate (disconnect the consciousness from what is happening). Later, this becomes a coping strategy that is used whenever the survivor feels overwhelmed.

Loss of intimacy
For survivors of sexual abuse, sexual relationships can either become something to avoid or are entered into for approval (since the child learns that sex is a way to get the attention they crave) and the person may be labeled ‘promiscuous.’

Loss of safety
The world becomes a place where anything can happen

Loss of danger cues
How do you know what is dangerous when someone you trust hurts you and this is then your ‘normal?’

Loss of trust
This is especially true if the abuser is a family member or a close family friend.

Shame
Huge, overwhelming, debilitating shame. As a child, even getting an exercise wrong at school can trigger the shame. The child may grow into an adult who cannot bear to be in the wrong because it is such a trigger.
TRAUMA-INFORMED CARE: KEY PRINCIPLES

- Safety
- Trustworthiness and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice and Choice
- Cultural, Historical, and Gender Issues
WHO SHOULD PRACTICE TRAUMA-INFORMED CARE?

EVERYONE!
WHO SHOULD PRACTICE TRAUMA-INFORMED CARE?

EVERYONE!

ONLY TRAINED CLINICIANS CAN PROVIDE TRAUMA THERAPY
Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment
INTEGRATED CARE

- Safety
- Control
- Connection
MULTI-DIMENSIONAL SAFETY

- Internal Safety
- Relational Safety
- Physiological Safety
- Environmental Safety
- Therapeutic Safety
- Agency/System Level Safety
SAFETY AND SUBSTANCE USE

Offer and provide balanced, transparent information about:

- Treatment services, requirements, eligibility, policies, expectations, privacy
- Safer consumption strategies and resources
- Withdrawal, tolerance, and overdose risk factors
- Medication assisted treatment
AVOIDING RE-TRAUMATIZATION

“We should make great efforts to do nothing that could be retraumatizing, such as exercising authority and/or control, asking intrusive questions, being unpredictable, or using shaming language/techniques.”

- Sheila Vakharia & Jeannie Little

https://www.researchgate.net/publication/301343562_Starting_Where_the_Client_Is_Harm_Reduction_Guidelines_for_Clinical_Social_Work_Practice
- Emphasize autonomy; people have a right to control their own bodies and make decisions about their lives
- Reframe risky behaviors as an attempt to take control by doing something to self-regulate
- Protect participant rights
- Ask permission
- Offer choices whenever possible
ADDICTION
CONNECTING

- Primary objective is keeping people engaged
- Healing takes place in the context of healthy connection
- People are generally safer in communities
“Being able to feel safe with other people is probably the single most important aspect of mental health; safe connections are fundamental to meaningful and satisfying lives.” – van der Kolk, 2014
TRAUMA-INFORMED INTEGRATED TREATMENT

- Recognize trauma as a defining and organizing experience
- Proactively create collaborative relationship that prioritizes individuals’ safety, choice, and control
- Understand the multiple, layered interactions between substance use and complex violence
TRAUMA-INFORMED INTEGRATED TREATMENT

- Simultaneously address substance use and complex trauma
- Empower individuals to engage in collaborative decision making during all phases of treatment
- Implement ancillary services for comprehensive, whole-person interventions
Lack of Integration

- Index search shows extremely limited mentions of trauma
- No meaningful discussion of integrated approaches
MOVING TOWARD INTEGRATED CARE
Integrated PTSD and Substance Use Disorder treatment for groups or individuals

- Cognitive-behavioral therapy (CBT) adaptations
- 25 topics, evenly divided among cognitive, behavioral, and interpersonal domains

(Najavits, 2002)
# SEEKING SAFETY: COPING WITH TRIGGERS

(Najavits, 2002)

<table>
<thead>
<tr>
<th>Substance Use Triggers</th>
<th>Trauma Triggers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeing a drug dealer</td>
<td>Hearing a child cry</td>
</tr>
<tr>
<td>Ads for alcohol</td>
<td>Anniversary dates of trauma</td>
</tr>
<tr>
<td>Drug paraphernalia</td>
<td>A sudden sound</td>
</tr>
<tr>
<td>Parties and social situations</td>
<td>Pain in your body</td>
</tr>
<tr>
<td>Money</td>
<td>Sad music</td>
</tr>
<tr>
<td>A beeper/cell phone</td>
<td>Someone who resembles your abuser</td>
</tr>
<tr>
<td>Celebrations</td>
<td>Being criticized or yelled at</td>
</tr>
<tr>
<td>A thought (&quot;Just one drink is ok&quot;)</td>
<td>A thought (&quot;I’m bad&quot;)</td>
</tr>
<tr>
<td>A feeling (excitement or anger)</td>
<td>A feeling (closeness or sadness)</td>
</tr>
<tr>
<td>A time of day or season (night)</td>
<td>A time of day or season (summer)</td>
</tr>
<tr>
<td>PTSD symptoms</td>
<td>Substance abuse symptoms</td>
</tr>
</tbody>
</table>
Fight The Good Fight – Cope with Triggers

- A trigger is anything that sets off PTSD symptoms or substance use
- What are the most common triggers?
- Stay far away from triggers
- Never “test yourself” with triggers
- Triggers are part of life – but you can “fight the good fight”
- Strive for balance
- Cope with triggers before, during, or after they occur
- Triggers can be very sudden

(Najavits, 2002)
Changing Who, What, and Where to Cope with Triggers

You can get to safety by changing who, what, and where
- **Who** are you with?
- **What** are you doing?
- **Where** are you?

In short, put as much space between you and the trigger as possible.

Create a safety zone by changing **who, what, and where**.

(Najavits, 2002)
MINDFULNESS-BASED SOBRIETY (MBS)

- Group curricula for intensive outpatient and residential levels of care
- Integration of:
  - Relapse Prevention Therapy
  - Acceptance and Commitment Therapy
  - Motivational Interviewing

(Turner, Welches & Conti, 2013)
MBS ACTIVITY: URGE SURFING

- Consider this exercise through the lens of trauma-informed care

(Turner, Welches & Conti, 2013)
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- What components work well?

• Enter your responses into the chat *

(Turner, Welches & Conti, 2013)
MBS ACTIVITY: URGE SURFING

- Consider this exercise through the lens of trauma-informed care
- What components work well?
- What concerns arise?

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(Turner, Welches & Conti, 2013)
MBS ACTIVITY: URGE SURFING

- Consider this exercise through the lens of trauma-informed care
- What components work well?
- What concerns arise?
- What changes might you implement?
  • Enter your responses into the chat *

(Turner, Welches & Conti, 2013)
INTEGRATING OUR APPROACH

- Thorough understanding of trauma-informed care
- Application of critical thinking skills
- Creative adaptations; one size does not fit all
- Commitment to growth and learning
INTENTION SETTING

- What are you already doing well that you want to continue?
- What is the MOST important thing you learned today?
- What is ONE specific change you will make moving forward?
REFERENCES AND RESOURCES


- Echo Parenting and Education: [https://www.echotraining.org/](https://www.echotraining.org/)


REFERENCES AND RESOURCES

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