Unresolved Childhood Trauma and its Connection to Substance Use

Jonna Byars, Ph.D, LPC, NCC
“One must not look hard to see that we are losing the battle against addiction”
Psychiatrist Ed Khantzian

“… if Complex PTSD were ever given its due the DSM would shrink to the size of a thin pamphlet”
Traumatologist John Briere
Learning Objectives

Understand the co-occurring prevalence of substance use and trauma

Identify ways unprocessed trauma manifests itself

Describe how substance use ameliorates trauma symptoms

Identify ways to help clients with trauma become aware of and change these coping strategies

Describe different approaches for helping clients become aware of and process their trauma
Presentation Outline

• Overview & Statistics
• Substance Use
• Trauma
• Treatment
There is a **40% - 60% relapse rate** in individuals with substance use disorders after completing treatment.

National Institute on Drug Abuse (2018)
A Missing Piece?

Approximately 70% of those who have a substance use disorder have a history of trauma exposure.

“Ritualized compulsive comfort-seeking (what traditionalists call addiction) is a *normal* response to the adversity experienced in childhood, just like bleeding is a normal response to being stabbed.”

Sumok, 2017
Disease Model of Addiction

“Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change the structure and how it works.”

National Institute on Drug Abuse
Claimed Advantages of the Disease Model

- Counteracts the moral model that blames people for their bad behaviors
- Reduces stigma
- Leads to treatment rather than punishment
- More funding for research; gets attention from Congress
- Locating addiction in the brain leads to new medications that target brain functioning to help people to recover
- Chronic nature of the disease puts relapse into perspective
Criticisms of the Disease Model

• Offers false hope that there is a medical cure for substance use
• Has not really been shown to reduce stigma
• It is based on the premise that drugs are inherently addicting (which has been disproven by research)
• It does not adequately account for the reality that people use substances to numb emotional pain or cope with difficult environments
Has anything changed?

“The very nature of addiction challenges society’s deeply held preconceptions about willpower and self control...Addiction is not a moral failing; it is a disease in which essential motivational and self-control systems of the brain are compromised.”

Nora Volkow (2015)
Adverse Childhood Experiences (ACEs) commonly found in substance users
Kiburi (2018)

- Recurrent and severe physical abuse (11%)
- Recurrent and severe emotional abuse (11%)
- Contact sexual abuse (22%)
- Growing up with alcoholic or drug user (24%)
- Growing up with a family member in prison (3%)
- Growing up with a family member with mental illness (19%)
- Growing up seeing your mother being treated violently (12%)
- Growing up with both parents not being present (22%)
ACEs and Substance Use

- People with an ACE score of 5 or higher are up to ten times more likely (Sumrok, 2017) to use illegal drugs, to report substance use, and to inject illegal drugs.

- Trauma causes neurological changes in the brain which increases the likelihood of abusing substances, whether it’s alcohol, cigarettes, heroin, cocaine.
Maybe its not about the substances

“...Our findings are disturbing to some because they imply that the basic causes of addiction lie within us and the way we treat each other, not in drug dealers and dangerous chemicals. They suggest that billions of dollars have been spent everywhere except where the answer is to be found.”

Vince Felliti, 2014
Why the Connection? 
Three Hypotheses

- **Self-medication hypothesis**: People with Post Traumatic Stress Disorder (PTSD) use substances in an attempt to cope with or counteract their symptoms.

- **High-risk hypothesis**: People who abuse substances have higher rates of trauma as a result of their substance use (usually due to lifestyle choices associated with the substance use).

- **Susceptibility hypothesis**: People who use substances are more susceptible to developing PTSD after exposure to trauma than those who do not use substances.
Research Support

- Several studies demonstrated the strongest evidence for support is the self-medication hypothesis, with some support for the high-risk hypothesis.
- However, there was no evidence to support the susceptibility hypothesis.
- Those who specialize in trauma contend that trauma is stored in the body and the substance use numbs the pain of the unprocessed trauma.
Expanding the Definition of Trauma

PTSD

Attachment Disorder

Complex Trauma
C-PTSD
PTSD Origins

• First officially recognized in the mid-1980s due to the data gathered by the National Vietnam Veterans Re-adjustment Study

• Classified as an anxiety disorder in the DSM-III, DSM-IV and DSM IV-R

• In the DSM 5 it was moved out of the anxiety chapter and into a new chapter “Trauma and Stressor-related Disorders”
Complex Trauma Origins

Judith Herman proposed “Complex Trauma”, a view of psychological trauma that did not conform to the framework of PTSD and was seen in people who suffered considerable domestic violence, child physical and sexual abuse and neglect and who were given diagnoses of various personality disorders.
Key Differences Between PTSD and C-PTSD

- PTSD is a mental health issue that can occur in people who have lived through a specific traumatic event or series of events that have a definitive time limit, or in many cases, only happen once. Trauma is often not interpersonal in nature.

- C-PTSD is the result of exposure to trauma over long periods of time, often during childhood. The trauma is interpersonal in nature.
Complex Trauma Domains of Impairment

- Attachment
- Affect Regulation
- Behavioral Control
- Biology
- Dissociation
- Cognition
- Self-concept
• Children have a biological instinct to attach
• Attachment provides a secure base
• We learn how to modulate our affective states through the attachment relationship with our primary caregiver
• An impaired or absent caregiver does not provide a secure base for secure attachment to develop
• Insecurely attached children grow up to be insecurely attached adults
Complex Trauma is an Attachment Disorder

- EMOTIONAL NEGLECT is often at its root, with or without physical abuse
- A child has no one in formative years to model relational skills that lead to intimacy
- When healthy relating is not modeled, survivors do not know how to maintain or find relationships, and believe people cannot be depended on or trusted
- Overreliance of their F preference to avoid true intimacy
- F preference is our bodies natural survival instinct in times of danger: fight, flight, freeze, fawn.
Substance Use Disorder as an Attachment Disorder

• Research demonstrates the prevalence of insecure attachments in adults with substance use disorders (Parolin & Simonelli, 2016).

• Attachment theory looks at substance use as both a consequence and a failed solution to an impaired ability to form healthy emotionally regulatory relationships…the underlying driving force behind all compulsive/addictive behavior is related to an inability to manage relationships (Flores, 2006, p. 6).

• The vulnerable individual’s attachment to chemicals serves both as an obstacle and as a substitute for relationships.
In the moment of trauma, the body goes into fight or flight mode. Loss of executive function is a protective response because cognition is too slow.

When re-traumatized, the brain responds in the same way: the cognitive brain deactivates and the emotional/instinctual brain acts as if the traumatic event is happening in the present – the person become furious, terrified, enraged, ashamed or frozen. *Stuck in fight/flight/freeze*
FLASHBACKS: Implicit vs Explicit

• Prolonged regressions to the overwhelming feeling states of the trauma experienced as a child. These states can include but are not limited to fear, shame, alienation, rage, grief, and depression.

• These emotional flashbacks trigger unnecessary fight/flight. The person is transported back in time, experienced as if it were happening in the present.

• In an implicit flashback, clients mistakenly believe someone or something in the present is causing these feelings.
Features of Left-Brain Dissociation

• Obsessiveness: cycling through worries, dwelling on one worry, constantly thinking to (unconsciously) distract from underlying pain.

• Complaining about trivial or mundane things instead of addressing the real pain.

• Trivialization: Over focusing on trivial, superficial, external concerns to distract from inner concerns. A preoccupation with sports statistics, for example.

• Intellectualization: An overreliance on reasoning to avoid looking at and dealing with feelings.
Features of Right-Brain Dissociation

- Right brain dissociation can be seen as classical dissociation, and the most common type.
- Numbing intense feeling or incessant inner critic attack. Dissociation is a process of distraction, fantasy, daydreaming, fogginess, TV, tiredness or sleep.
- Getting lost in daydream-like descriptions of improbable salvation fantasies or in the recounting of long elaborate dreams devoid of emotional content and serious introspection.
Identifying Unprocessed Trauma

When humans are in danger or threatened, the sympathetic nervous system is activated, and our survival instincts respond with one of the four responses:

- Fight
- Flight
- Freeze
- Fawn
The “Four F” Responses Become Ingrained

• Traumatized children over-gravitate towards one of these responses - as time goes on, this provides their survival and defense mechanism for coping, often at a pre-verbal age.

• This response helps them survive but leaves them limited in learning other ways to respond in life. They may become locked into this pattern into adulthood.

• People with “good enough” parenting fluctuate between healthy manifestations of these F types and use them flexibly in times of danger.
### Positive Characteristics of the Four Fs

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<th>Fight</th>
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<th>Freeze</th>
<th>Fawn</th>
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<tr>
<td>Assertiveness</td>
<td>Disengagement</td>
<td>Awareness</td>
<td>Love and Service</td>
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<td>Boundaries</td>
<td>Healthy Retreat</td>
<td>Mindfulness</td>
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<td>Courage</td>
<td>Industriousness</td>
<td>Readiness</td>
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<td>Moxie</td>
<td>Know-how</td>
<td>Peace</td>
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<td>Leadership</td>
<td>Perseverance</td>
<td>Presence</td>
<td>Peacemaking</td>
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People without trauma history fluctuate between healthy manifestations of these types and use them flexibly throughout life.
### 4F DISTORTIONS OF ATTACHMENT AND SAFETY INSTINCTS

Pete Walker, M.A. Psychotherapy (pete-walker.com)

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<tr>
<td>Control to Connect</td>
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<td>No Way I’ll Connect</td>
<td>Merge to Connect</td>
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<tr>
<td>Rage to be Safe</td>
<td>Perfect to be Safe</td>
<td>Hide to be Safe</td>
<td>Grovel to be Safe</td>
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Factors That Influence “Four F” Type Preference

Type of abuse and its pattern
Birth order
Genetic predispositions
Clients May be Misdiagnosed Based on F-type

Overreliance on an F-type into adulthood could lead a client with CPTSD to look like a particular diagnosis.

- **Fight – Narcissist; Antisocial**
- **Flight - OCD; anxiety; substance use; ADHD; Bipolar**
- **Freeze - dissociation; depression; dysthymia; schizotypal; Asperger’s; Avoidant**
- **Fawn - Dependent personality disorder; depression; lack of sense of identity; borderline**
The Inner Critic

- One of the key defining components differentiating PTSD and C-PTSD
- The disgust, rage, scorn, or neglect the parents felt towards the child is taken on as their own voice
- Disgust causes shame
- Look for it with all cases of depression, anxiety, and any type of substance abuse or process addiction
How The Inner Critic Develops

- When children fail to receive validation or approval from parents, they fail to form an attachment and become anxious and fearful. Children adapt to this environment by developing HYPERVIGILANCE and/or PERFECTIONISM.

- The perfectionistic seeking/hypervigilant child can only think of HOW they are not good enough based on parents' words of affection or lack of words or affections.

- The child's sense of self has no room to develop and becomes that of the messages their parents have sent (or not sent) and the inner critic develops.
Critic Induced Flashbacks

- EXAMPLES
- Spilled milk ("klutz")
- Giving gift ("stupid")
- Mis-speaking ("clueless")
The Outer Critic

• While the inner critic views self as flawed and unworthy, the outer critic views the rest of the world as flawed and imperfect.

• Uses the same programing of perfectionism and endangerment against others that the inner critic uses against self.

• Is a consequence of untrustworthy parents, generalized to all others to avoid emotional investment in relationships.

• Relationship/Intimacy killer.
Intimacy and the Outer Critic

C-PTSD is an attachment disorder.

Childhood development without a sympathetic caregiver means that a child may not understand that other people can help with feelings of loneliness or other emotional pain. Drawing on childhood experience, the outer critic says that people are dangerous and cannot meet those needs. The deeply ingrained memories of unsupportive parents stifle the possibility of seeking help and intimacy.
The Outer Critic Alienates Others

Passive-Aggressiveness and the Outer Critic

Parental abuse or neglect naturally makes children angry – but the power of parents is such that the anger cannot be expressed. Unexpressed childhood anger can become a vast reservoir of resentment that is projected onto others, through passive-aggressiveness. The outer critic thrives on judgmental condemnation and hurtful, backhanded behavior.
Critic and Disassociation Types

• Fight - Outer Critic; Left Brain dissociate
• Freeze - Outer Critic; Right Brain dissociate
• Fawn - Inner Critic; Fluctuate between Left/Right Brain dissociate
• Flight - Vacillation between the Inner and Outer Critics; Left Brain dissociate
What does it look like?
It requires a paradigm shift away from a traditional substance use treatment approach toward one that utilizes the principles of trauma informed care.
• C-PTSD is a learned set of responses which results in the inability to complete some developmental tasks. It is ENVIRONMENTALLY, NOT GENETICALLY caused. This often differentiates it from other diagnoses.

• Treatment is influenced by the mechanisms individuals have been using to cope with their CPTSD (addiction, sleeping too much, eating disorder, depression), their F type, and their inner/outer critic stance.
Treatment can be Re-Traumatizing and Trigger 4 F Response

- Concept of powerlessness
- Absolute authority of the counselor
- Confrontation tactics
- Shaming practices
- Focus on ‘character defects’
- “Addicts can’t be trusted to tell the truth”
- Discharges for “non-compliance”
- Punishing aggression
- No choices
- Withholding medication-assisted treatment
12 Step Programs

- Can be a valuable community support and an adjunct to evidence-based treatments
- This relationship-based program of recovery can be both healing and triggering to a traumatized individual
- Unwillingness to participate is a common and expected reaction of someone who has experienced trauma in relationships
- Relationships are dangerous, but what is damaged in relationships can only be healed in relationships
Implications for Treatment

• It is no longer adequate to treat substance use disorder as a primary and singular disorder.

• It is important to critically examine how we do substance use treatment today and be willing to change our practices so that we are responsive to the trauma our clients have experienced.

• Trauma informed treatment and trauma specific interventions must become an integral part of substance abuse treatment.

• Even clients who do not have a significant trauma history will respond positively to a trauma informed approach.
• For many individuals, addictive behaviors are an adaptation to traumatic experiences.

• The disease model has its usefulness, but the risk is that we seek only to intervene through the brain and ignore the body and the mind-body connection.

• We need to re-focus our treatment to start from the bottom-up.
The Focal Points of Trauma Treatment

Cognition
Emotion
Body
• Individuals seeking help often will not present with ‘C-PTSD’.
• Until some fight response is restored, clients benefit little from Cognitive Behavioral Therapy or psychodynamic therapy.
Treatment at the Cognitive Level: Develop Awareness

- Goal: To separate individuals from their inner critic
- Help client develop insight into the abuse/neglect pattern
- Affirm that they didn’t deserve to be treated this way
- Introduce them to the F response notion. This helped them survive in childhood, but they are safe now. Awareness of when and how they use their F response.
- Help them see connection to how they were treated with how they now respond to stress
Cognitive Healing

• Cognitive healing involves finding more accurate ways of thinking about and talking to oneself. This includes recognizing the source of the poor self-perception and placing the blame on the actual wrongdoers. Cognitive work can be critical in the process of disidentifying from the self-hating critic.

• Cognitive tools and CBT are important, but many who struggle with CPTSD have discovered that it cannot by itself address the full depth of the woundedness that is present. Emotional tools are important.
Cognitive work helps a client disidentify with the critic. Many are so entrenched with their critic it is a PART of them ALL the time.
Reparenting consists of affirmation rather than punishment. Judgment is self-rejecting and counterproductive. Repeated, simple mental and verbal affirmations can be useful. Reparenting can include “self-mothering” and “self-fathering”.

Emotional Healing

One strategy for reconnecting with the emotional self is through grieving. A person can be led through a process of grieving what they have lost because of trauma or neglect in childhood. It is a death of part of oneself, which may allow a rebirth of emotional intelligence. Grieving quiets both the outer and inner critic and may stop flashbacks in the moment.
Grieving

- ANGER
- A strong caution: anger can send an individual into a flashback if they were punished for expressing strong emotions in childhood.
Emotional Healing

Verbal ventilation can allow the speaking out of painful feelings. Allowing feelings to come out verbally can, for example, lead a person out of flashback by giving voice to the emotions of the hurt child, allowing the adult the child has become to feel the pain. Acknowledged in that way, the pain can be mourned. Verbal ventilation quiets the inner critic.
The Inner Critic Resists Grieving

- “Quit crying, or ill give you something to cry about.”
- Grieving may lead an individual into a flashback, recalling words spoken by parents.
- Some trauma survivors must learn to quiet the inner critic before they can begin the grieving process.
Loneliness

- The shame that binds an individual to loneliness must be healed.
- Group work can be very effective in healing relational shame. There is often more mutual vulnerability in group work compared to one on one settings.
Mindfulness

What we sometimes call the “witnessing self” or the “observing ego” is an important tool. Time for genuine reflection may allow a person to distinguish between things they actually believe and things they have been pressured to believe about themselves.

Awareness of one’s self-commentary can be practiced, and with enough practice one may be able to replace harmful viewpoints with thoughts that are self-supportive.
• All trauma is preverbal; the traumatized body re-experiences terror, rage and helplessness, but these feelings are almost impossible to articulate.

• Survivors develop “cover stories” to explain their symptoms and behaviors; these stories rarely capture the inner truth of the experience.

• The experience of trauma shows up in instinctual responses such as fight, flight, freeze, submit and attach.
“Good Enough” is a term used by scholars and therapists to describe the discarding of perfectionistic, unrealistic attitudes toward relationships. It adopts reasonable expectations of good-heartedness and consistency in the support, protection, forgiveness, and comfort one receives from a parent or other important relationship.
Avoiding the Gratitude Trap

• Asking CPTSD clients to find things to be THANKFUL for can send them to flashback. Many were told ‘just be thankful’ or ‘you are so entitled’, etc.

• Present the notion of finding things that are “good enough” and see if client can generate things versus ‘finding X amount of things per to be grateful for per day’.
• Spirituality has great potential to help in recovery.
• A big part of a CPTSD childhood is feeling unwelcome, it makes sense that a transcendent sense of belonging is attractive - belonging to something greater, having a sense of place.
Working with the Body

• Movement oriented activities should move from the adjunctive therapy list to the primary therapy list and should incorporate sensorimotor approaches.

• Once the body settles, it makes it easier to work through the emotional and the cognitive modalities to heal trauma.
Angering and grieving the losses of childhood begin with awareness of the patterns that were established and ingrained from an early age. With practice, the inner critic can be silenced and recovery made a way of life for those affected by CPTSD. This is a step towards avoiding the need to numb the pain of unprocessed trauma with substances.
What do you think?

Can we change how we approach substance abuse treatment?
References


