From Treatment to Long-Term Recovery

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Learning Objectives

• Describe the role of behavioral health professionals in supporting long-term recovery
• Describe the role of the individual in long-term recovery
• Identify areas of identity, character, and relationships that lead to long-term recovery
• Understand the role of unprocessed trauma in long-term recovery and discover effective treatment modalities for processing trauma as it relates to long-term recovery
• Identify the skills necessary to help individuals with long-term recovery-focused rebuilding of identity, relationships, and support networks
Presentation Outline

- Addiction definition and statistics
- Current short term recovery treatments
- Long-term adherence rates
- Short-term treatment methods
- What does long term recovery mean:
  - Role of counselor
  - Role of individual
- Trauma and its role in long term recovery
Definition 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
Substance Use Relapse Statistics

“There is a 40% - 60% relapse rate in individuals with substance use disorders after completing treatment.”

American Addiction Centers

“Alcohol and opioids have the highest rates of relapse, with some studies indicating a relapse rate for alcohol as high as 80 percent during the first year after treatment. Similarly, some studies suggest a relapse rate for opioids as high as 80 to 95 percent during the first year after treatment. Other substances with notoriously high relapse rates are stimulants and benzodiazepines.”

The Hazelden Betty Ford Foundation
Short-Term Treatment Steps for Substance Use Disorder

- Detoxification
- Behavioral counseling
- Medication (for opioid, tobacco, or alcohol addiction)
- Evaluation and treatment for co-occurring mental health issues such as depression and anxiety; Posttraumatic Stress Disorder (PTSD), cross addictions
- THEN, long-term follow-up to prevent relapse
The Role of Substance Use Disorder Professionals in Supporting Long-Term Recovery

Role of Counselor in Substance Use Disorder Recovery

- Therapeutic alliance
- Encourage and create individual continued recovery plan
- Help individuals develop a relapse prevention plan
- Meet with family members to provide guidance
- Refer individuals to outside support groups
Continued Recovery Plan

- Consistent scheduled counseling and psychiatric care
- Consistent scheduled primary care
- Consistent planned and scheduled support groups
- Consistent schedule family plan
- Identify feelings of unworthiness - the hole.
- Co-occurring diagnosis treatment and identification
- Include trauma and cross addiction identification
Relapse Prevention Plan

- Identifying High Risk Situations
- Coping with Stress, Triggers, and Conflict.
- Dealing with Shame
- Ongoing Monitoring of Co-Occurring Disorders: Anxiety and Depression
- Trauma and Cross Addiction
The Role of the Individual in Long-Term Recovery

- “80% of success is showing up” - show up for meetings and appointments
- Reach out for support
- How people who have stayed in recovery define recovery: abstinence, truth, and service
Recovery Model

• An approach to mental health disorder or substance dependence that emphasizes and supports a person's potential for recovery. Recovery is seen as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning. Recovery sees symptoms as a continuum of the norm rather than an aberration and rejects sane-insane dichotomy.
Identity

- Inverse relationship with higher use of intoxicants correlating with lower levels of identity development
- Those with substance use disorders gradually lose, surrender, or discard aspects of themselves to assume their new social identity when using
- Becoming aware of change
- Slow movements towards getting back to where they were
Relationships

• Those with substance use disorders have lower perceived social support
• Crux of recovery
• Need knowledge of healthy relationships: boundaries and communication
• Examine previous relationship patterns and style
• Attunement and attachment
• Trauma and co-occurring disorder impact
Trauma: A Missing Piece to Long-Term Recovery?

Approximately 70% of those who have a substance use disorder have a history of trauma exposure that is resistant to short-term care.

(Khoury et al., 2010)

“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.”

Dr. Dan Sumok, 2017
Adverse Childhood Experiences (ACEs) Commonly Found In Relapsing Individuals

- 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%)

(Kibury et al., 2018)
ACEs and Substance Abuse

• People with an ACE score of 5 or higher are up to ten times more likely to use illegal drugs, to report substance use, and to inject illegal drugs. Relapse rates for those with trauma are twice as high as those without.

• Trauma causes neurological changes in the brain which increases the likelihood of abusing substances, whether it’s alcohol, cigarettes, heroin, cocaine.
Maybe it’s 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?
Two Hypotheses

• **Self-medication hypothesis**: People with Posttraumatic Stress Disorder use substances in an attempt to cope with or counteract their symptoms.

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

• **Several studies** demonstrated the strongest evidence for support is the self-medication hypothesis, with some support for the high-risk 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 that Effects Long-Term Recovery from Substance Use Disorders

- PTSD
- Attachment Disorder
- Trauma Complex PTSD
Key Differences Between PTSD and C-PTSD

• PTSD is a mental health condition 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.

• Complex PTSD (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
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 making finding support in long-term recovery difficult
- Use their fight/flight/freeze/fawn preference to avoid true intimacy
The Impact of Trauma

- 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 and Impact on Long-Term Recovery

• 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, persons mistakenly believe someone or something in the present is causing these feelings.
Features of Left-Brain Dissociation From Trauma and its Effect on Long-Term Recovery and Identity

- 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 from Trauma and its Effect on Long-Term Recovery and Identity

- 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
## Positive Characteristics of the Four Fs and Recovery

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<thead>
<tr>
<th>Fight</th>
<th>Flight</th>
<th>Freeze</th>
<th>Fawn</th>
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<tbody>
<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>
<td>Compromise</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 f-types and use them flexibly throughout life.
### 4F Distortions of Attachment and Safety Instincts

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<tbody>
<tr>
<td>Control to Connect</td>
<td>Perfect to Connect</td>
<td>No Way I’ll Connect</td>
<td>Merge to Connect</td>
</tr>
<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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Individuals May Be Misdiagnosed Based On F-Type; Co-occurring Diagnosis Implications and Examples

| Overreliance on an F type into adulthood could lead an individual with C-PTSD to look like-particular diagnosis |
| Flight – Narcissist; Antisocial |
| Flight- Obsessive-compulsive disorder (OCD); anxiety; addiction; Attention-Deficit / Hyperactivity Disorder (ADHD); Bipolar |
| Freeze- dissociation; depression; dysthymia; schizotypal; Asperger’s; Avoidant |
| Fawn- Dependent personality disorder; depression; lack of sense of identity; borderline |
The Inner Critic and its Role in Long-Term Recovery

• 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 use 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 and interference with recovery

• EXAMPLES
• Spilled milk ("klutz")
• Giving gift ("stupid")
• Mis-speaking ("screwup")
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 programming 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
The outer critic alienates others and prevents support seeking in long-term recovery.

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.
Trauma Informed Treatment for Long-Term Recovery

What does it look like?
It requires a paradigm shift away from a traditional substance use disorder treatment approach toward one that utilizes the principles of trauma informed care.
Treatment

• 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 they have been using to cope with their trauma (addiction, sleeping too much, eating disorder, depression), their F type, and their inner/outer critic stance.
Substance Use Disorder 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 treatment today and be willing to change our practices so that we are responsive to the trauma individuals have experienced.
• Trauma informed treatment and trauma specific interventions must become an integral part of substance use disorder treatment.
• Even people who do not have a significant trauma history will respond positively to a trauma informed approach.
Rethink Treatment for Long-Term Recovery

- For many individuals, substance use 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
Treatment

- Individuals seeking help often will not present with ‘C-PTSD’.
- Until some fight response is restored, persons benefit little from Cognitive Behavioral Therapy (CBT) or Psychodynamic Therapy.
Treatment at the Cognitive Level: Develop Awareness

- Goal: To separate them from their inner critic
- Help individual develop insight into the abuse/neglect pattern
- 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 Cognitive Behavioral Therapy are important, but many who struggle with C-PTSD have discovered that it cannot by itself address the full depth of the woundedness that is present.
Cognitive work helps an individual disidentify with the critic. Many are so entrenched with their critic it is a PART of them ALL the time.
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 due to 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 I’ll 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.
Trauma Is Stored In The Body

- 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 individuals with C-PTSD 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 the person can generate things versus ‘finding a certain number of things to be grateful for each day’.
Spirituality

• Spirituality has great potential to help in recovery.

• A big part of a C-PTSD 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 C-PTSD. 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 use treatment to include trauma care to help increase long term adherence and recovery?
References


