Establishing Safety: Treating Trauma in Early Recovery

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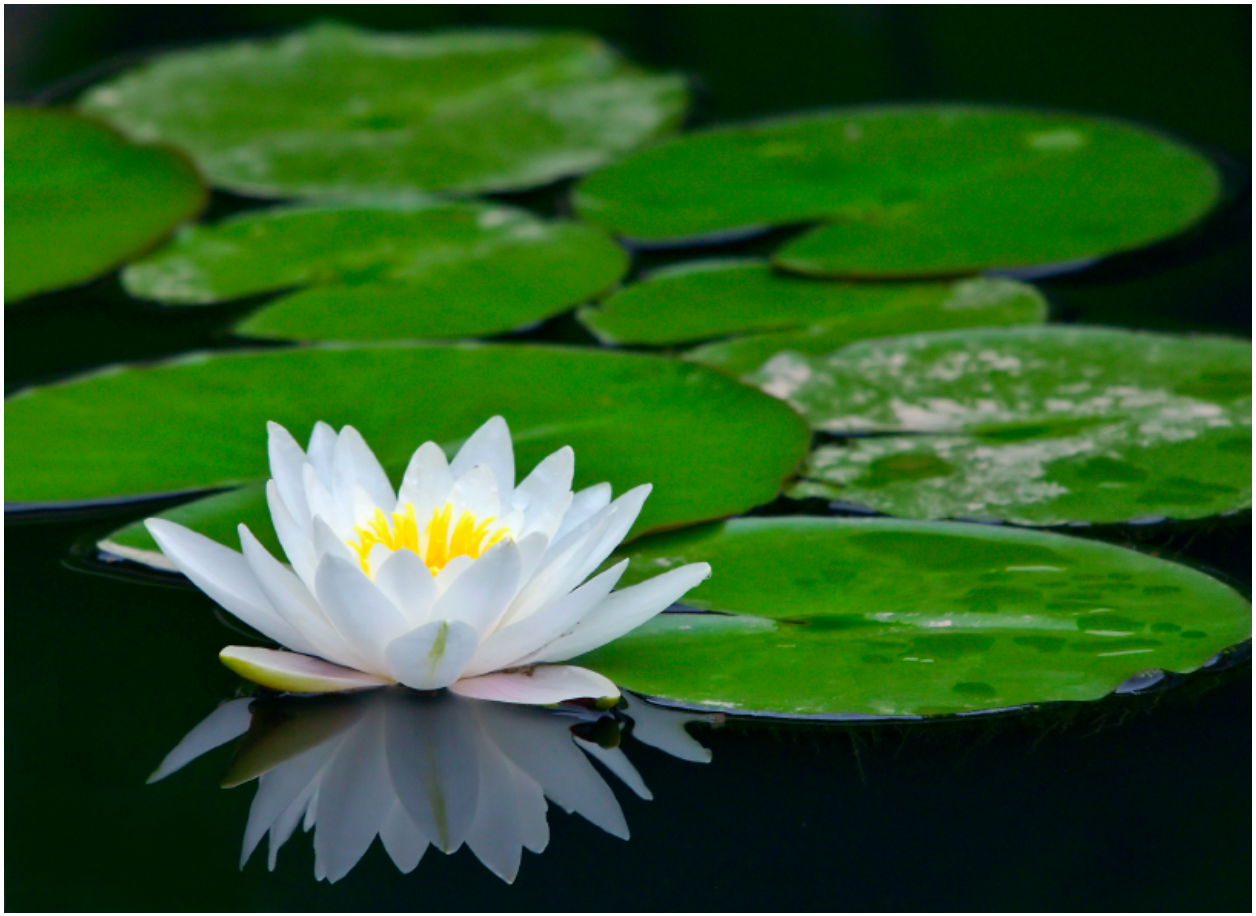
“Out of Suffering Emerged the Strongest Souls; the Most Massive Characters are Seared with Scars” –Kahlil Gibran



What is TRAUMA?

DSM V definition:

Exposure to actual or threatened death, serious injury, or sexual violence by:

- Direct Witnessing the event
- Learning of an event that occurred to a close person
- Experiencing repeated or extreme exposure to aversive details of the event (does not apply to media except when it is work related).

Adapted from DSM V

Potentially Traumatic Events

- Childhood Abuse (physical, sexual, emotional)
- Disaster (natural or human)
- Armed robbery
- Physical and Sexual Assault
- Severe accidents (fire, injury, torture)
- Military combat
- Kidnapping
- Terrorist attacks
- Torture

Symptoms of PTSD
Note: lasting >1 month

Reexperiencing	Avoidance	Hyperarousal	Mood and Cognitive Changes
• Nightmares • Flashbacks • Intrusive thoughts • Increased physiologic response to triggers/cues	• Avoiding thinking or talking about trauma • Avoiding trauma reminders	• Sleep disturbance • Irritability and Anger outbursts • Easily Startled • Trouble Concentrating • Hypervigilance • Reckless and self detructive behavior	• Negative beliefs about self and the world • Feeling numb and detached • Persistent negative emotions and inability to have positive emotions.

Trauma Statistics

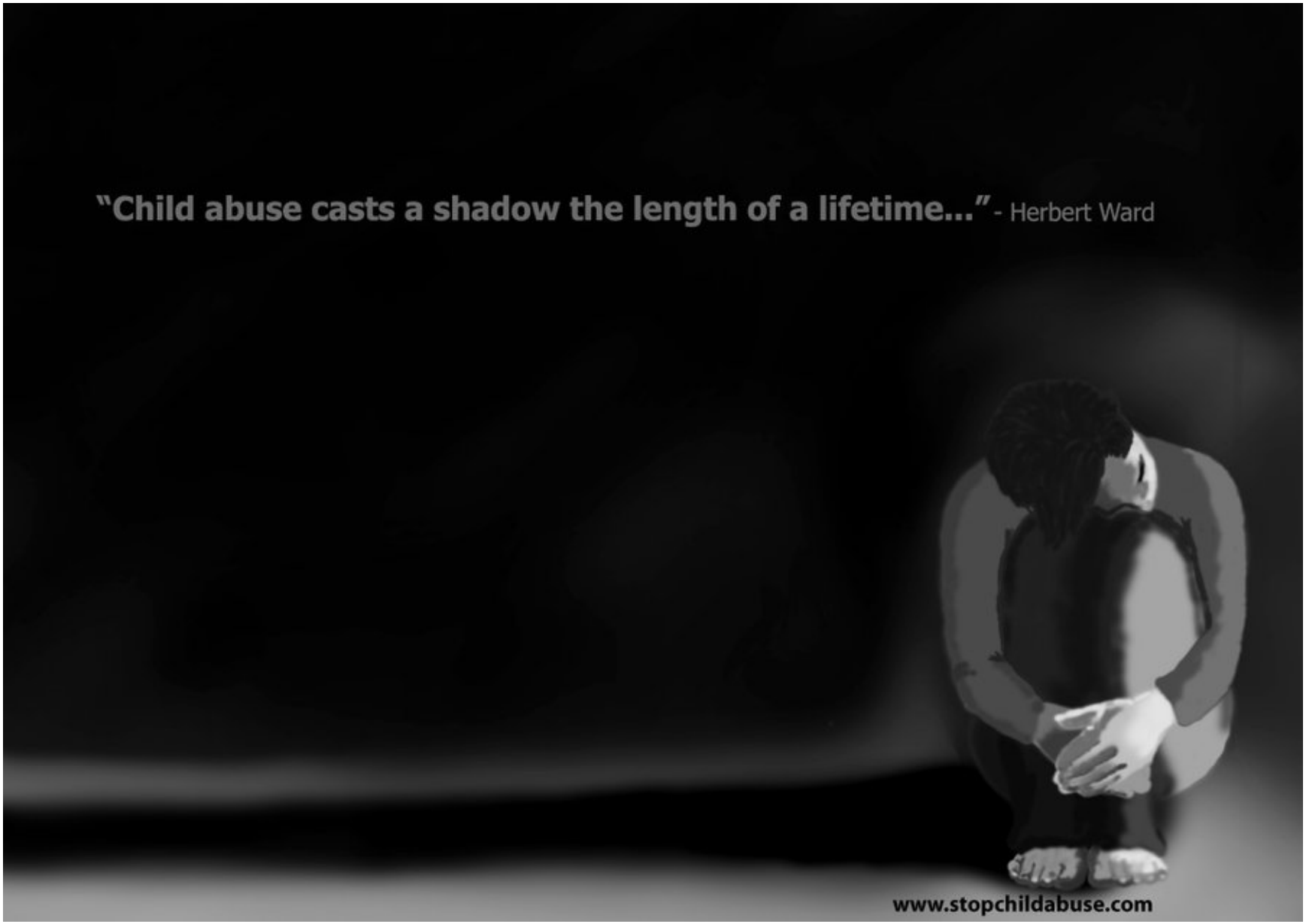
70% of adults in the U.S. have experienced some type of traumatic event at least once in their lives. Up to 20% of these people go on to develop PTSD.

An estimated 8% of Americans have PTSD at any given time.

An estimated 1 out of 10 women develop PTSD and women are about twice as likely as men to develop PTSD

Almost 50% of all outpatient mental health patients have PTSD

National Center for PTSD; Mills et. al. JAMA August 15 2012 Vol 308


"Child abuse casts a shadow the length of a lifetime..." - Herbert Ward
www.stopchildabuse.com

Childhood Trauma

- Early childhood neglect shown to be correlated with generally lower intelligence.
- Chaotic and unpredictable environments lead to brain dysregulation and dysynchrony.
- Younger age less active “fight or flight response.” Dissociation more common.

2013 Kendall Tackett Treating Lifetime Heath Effects of Childhood Victimization 13-2, 13-3

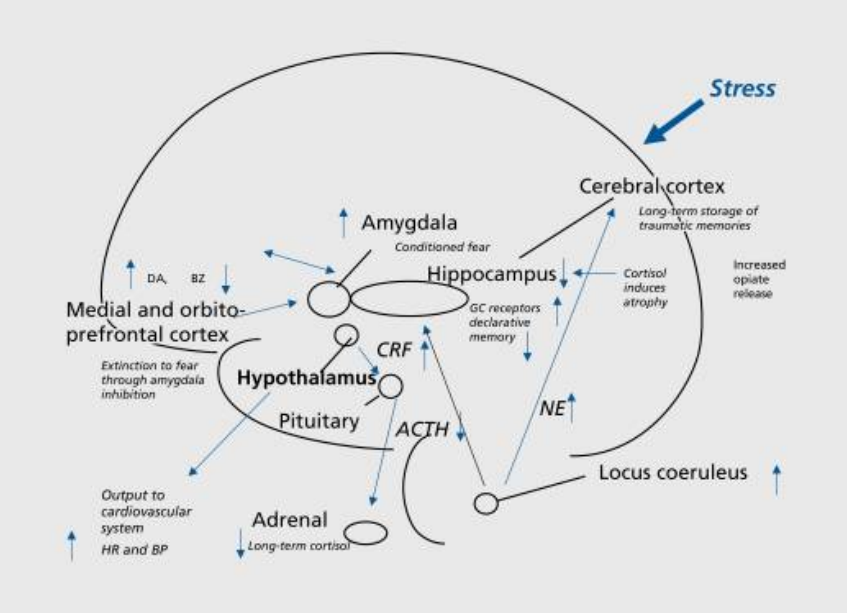
Childhood trauma Statistics

- In 2011, child protective services in the United States received 3.4 million referrals
  - (78.5%) suffered neglect
  - (17.6%) suffered physical abuse
  - (9.1%) suffered sexual abuse
- 5% of adolescents have met criteria for PTSD in their lifetime.
  - Prevalence is higher for girls than boys (8.0% vs. 2.3%) and increase with age (4).

Conditions Associated with Child Abuse

- Post Traumatic Stress Disorder
- Major Depressive Disorder
- Anxiety Disorders (panic disorder)
- Personality Disorders (borderline personality disorder)
- Eating Disorders (bulimia/binge eating disorder)
- Substance use disorders
- Somatization Disorders/Pain disorders

Trauma and the Brain



Traumatic stress: effects on the brain
J. Douglas Bremner
Dialogues Clin Neurosci. 2006 December; 8(4): 445–461.

- Trauma leads to upregulation of Amygdala (fear response) and stress hormones (norepinephine and cortisol)
- Long term trauma causes decreased cortisol and increase in DA.
- Hippocampal volume shrinks in response to trauma
- Dissociation is result of Dopamine upregulation which leads to increase in opioids and altered pain sensitivity

Trauma and the Family

Parentification of Children

Children learn to put needs put aside learn to make connections through taking care of others.

Children are put in developmentally inappropriate settings and are left with feelings of inadequacy

Inaccessiblity of of parents

Children feel on their own and develop loss of trust and faith in relationships

Secrecy

Children learn to deny aspects of their reality

Become unable to form authentic honest attachments.

Complex PTSD

- Chronic cumulative trauma
- Often invasive and interpersonal
- Respond differently to treatment
  - Child abuse
  - Chronic domestic abuse
  - Hostage situations
  - Religious cults
  - Slave labor camps

Kendall-Tackett 2013 Treating Lifetime Health Effects of Childhood Victimization

Complex PTSD Symptoms

Behaviors	Cognitions	Emotions	Social
• Self-destructive • Tension reducing • Impulsive	• Low self efficacy • Distorted reasoning • Learned Helplessness	• Affect Disregulation • Emotional constriction • Shame/Guilt • Depression	• Inability to trust • Poor boundaries

Impact of ComplexTrauma National Child Traumatic Stress Network www.nctsn.org

Vunerability Factors for PTSD

Pretrauma:

- history of prior trauma
- female gender
- poor distress tolerance
- insecure parental attachments

Trauma:

- sudden and unpredictable
- involve physical injury or sexual abuse
- occurs before personality is fully integrated.
- Chronic in nature

Posttrauma:

- lack of support
- secondary victimization
- avoidance
- ineffective coping (using substances)

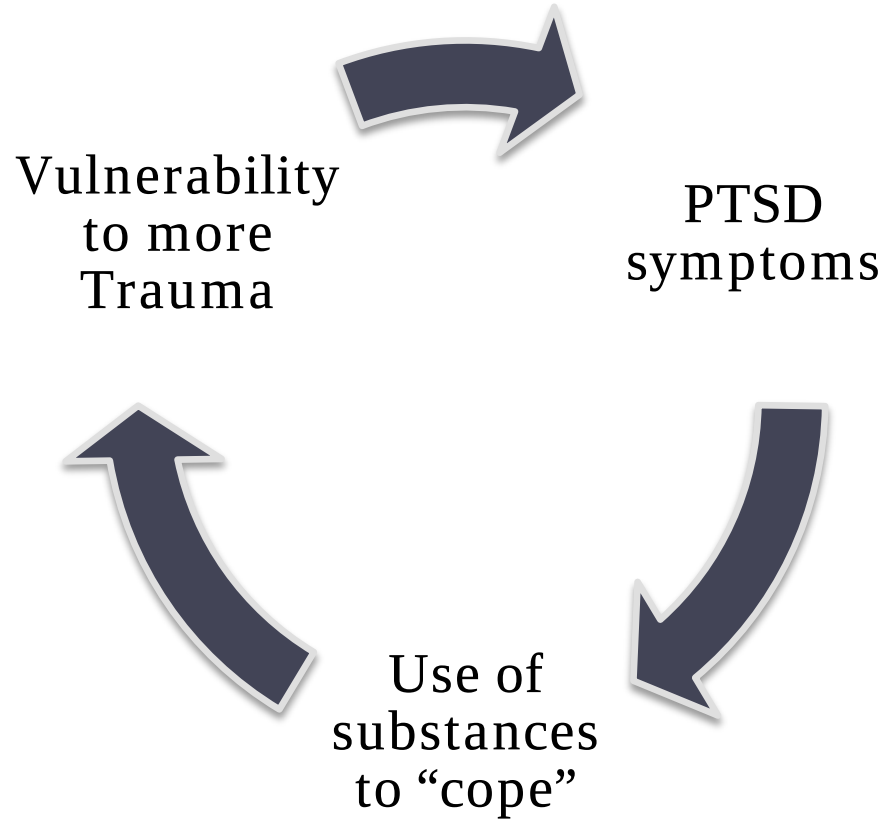
PTSD and Substance Use Disorders (SUDS)

- **65% of patients with PTSD have a comorbid substance disorder**
- **62% of substance abusers will develop PTSD**
- People with PTSD abuse dangerous substances:
- Studies indicate that opiate abuse occurs in approximately 23% of PTSD cases. This is followed by marijuana (20%), Benzodiazepines (11%), and cocaine (8%). Alcohol Abuse is (5%)

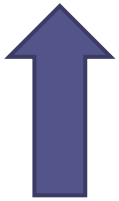
PTSD patients incur about $6000 per year in treatment costs in SUDS treatment centers.

Mills et al. 2012

Downward Spiral of PTSD and SUDS



Complex Relationship PTSD and SUDS

Substance Abuse can  **or**  PTSD symptoms

Abstinence  **or**  PTSD symptoms

Core Client Issues with PTSD/SUDS

- Splitting:
  - Parts of self are fragmented or walled off
- Triggering:
  - Altered reactivity to trauma related cues
- Boundaries
  - Relationships either too close or too distant
- Demoralization
  - Intense sense of personal failure and loss of sense of self worth.

Najavts et al. 2006

Treatment Challanges PTSD and SUDS

- Psychiatric and medical comorbidity the norm
- Psychosocial concerns
- PTSD symptoms can worsen with initial abstinence.
- Separate treatment systems difficult to coordinate care
- Fragile treatment alliances
- Frequent crises make getting to core issues difficult and elusive.

NIDA Collaborative Cocaine Study: Comborbid PTSD and SUDS:

Study 1991 and 1997 558 cocaine dependent patients

Found that patients with PTSD and SUDs:

- More chronic medical issues
- Cardiovascular, neurologic, body pain
- Greater levels of psychopathology
- Less likely to comply with aftercare
- More interpersonal problems

The National Institute on Drug Abuse Collaborative Cocaine Treatment Study: rationale and methods. Arch Gen Psychiatry 1997; 54:721–726

Barriers to Treatment PTSD/SUDS

Patient Driven barriers

- Trust Issues
- Fears about clinician's ability to handle information
- Possible amnesia
- Self-blame and shame
- Fear that talking about the trauma will worsen symptoms

P.C. Ouimette et al. 1998

Barriers to Treatment for PTSD/SUD

Provider Driven Barriers:

Substance Abuse providers:

- not screening for trauma appropriately.
- not referring patients to treatment for PTSD
  - In a study 40% of a sample had significant trauma history and only 15% had chart diagnoses. When diagnosis was present treatment was rarely part of treatment plan (P.C. Ouimette et al. 1998)
- Pervading Belief among clinicians that sobriety has to be maintained first before trauma work can begin.

P.C. Ouimette et al. 1998

PTSD and Substance Abuse

- “Providers of care for substance use disorders do not regularly screen for PTSD and do not make appropriate treatment referrals. Similarly, trauma experts insufficiently consider the co-occurrence of substance use disorders. Given the extraordinary suffering that occurs in both conditions and is amplified even more when they co-occur, a tragic shortfall too often develops in meeting the needs of patients who suffer with these conditions.”
  EDWARD J. KHANTZIAN, M.D.

From a trauma survivor's perspective…

Treatment Strategies for PTSD/SUD

Sequential Treatment treat one disorder then the other	• Most common paradigm in substance abuse treatment centers. Most often treat SUDs then PTSD.
Concurrent Treatment treat each disorder separately but simultaneously.	• For example sending SUD patient for outside therapy appointments to treat PTSD
Integrated Treatment treat both disorders at the same time.	• Example Seeking Safety : manualized CBT group psychotherapy approach that addresses both disorders (Najavits et al 1998).

Integrated Treatment Mills et al.2012:

- 103 pts who met DSM IV criteria for PTSD and SUD
- Randomized to receive substance abuse treatment as usual or COPE (Concurrent treatment of PTSD and SUDS using Prolonged Exposure therapy).
- From baseline to 9 month follow up treatment group demonstrated significantly greater reduction in PTSD symptoms
- No significant increase in severity of substance abuse (mean difference -16.9).

Evidence Based Treatment for PTSD

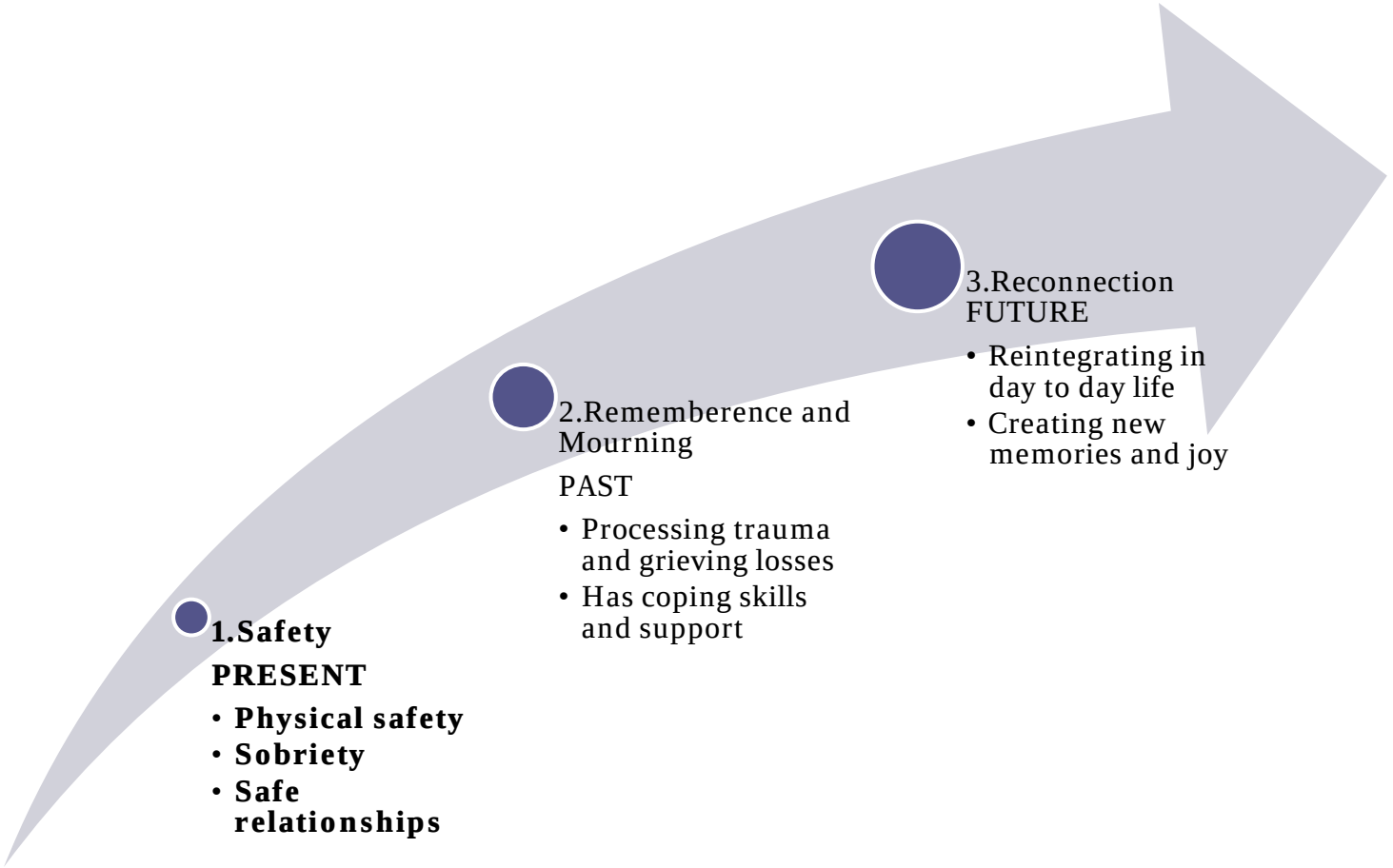
- Psychotherapy: First Line
  - Cognitive therapy
  - Exposure therapy including EMDR
  - Relaxation techniques
  - Education about PTSD

- Medications: Antidepressants; mood stabilizers, antipsychotics; blood pressure medications (prazosin).

Seeking Safety Najavits et. al 2002

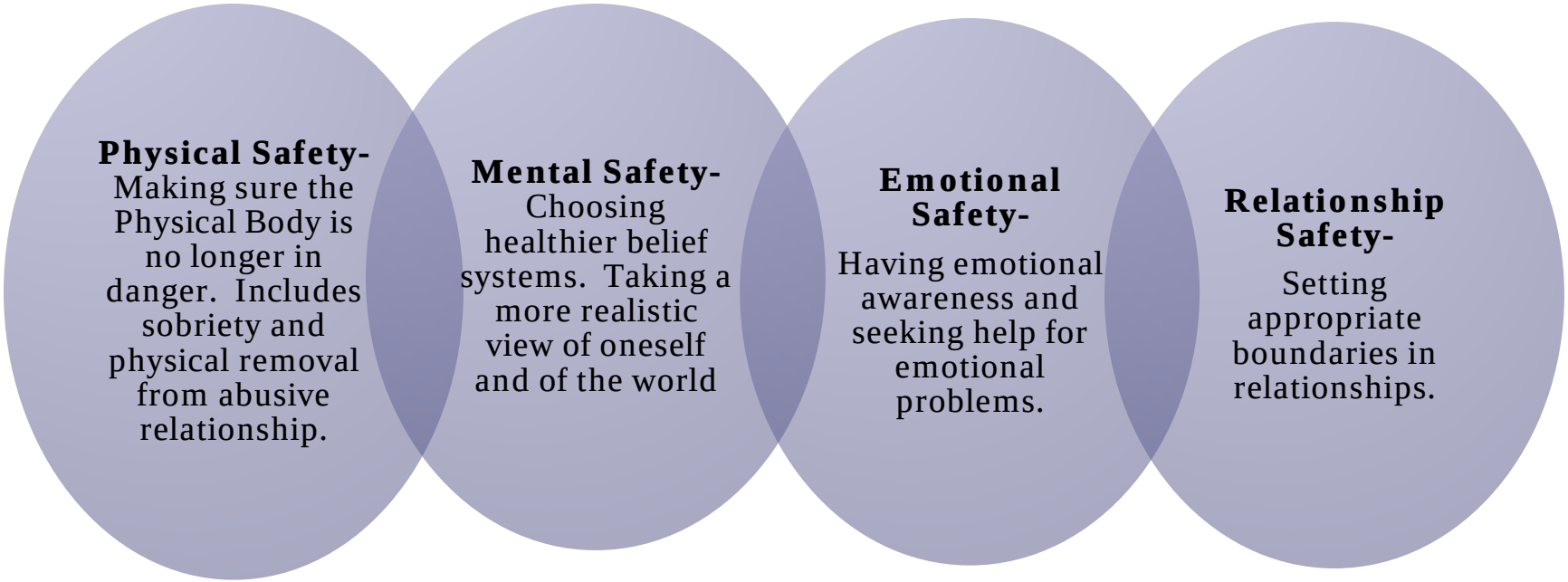
- Present centered CBT group therapy to help clients attain safety from PTSD and Substance Abuse.
- 25 topics that can be conducted in any order or used separately
- Evidence supports its use in a variety of treatment settings with men and women.
  - Safety is the goal of treatment
  - Integrated Approach
  - Focus on cognitive, behavioral, interpersonal Optimistic focusing on strength and future

3 Stages of Healing from Trauma (Herman1992)



Trauma and Recovery: The Aftermath of Violence--from Domestic Abuse to Political Terror
Judith Herman 1992

Types of Safety (Najavits 2002)



Establishing safety

- Psycho-education
  - Normalization
  - Removing Self Blame and Doubt
  - Correcting Cognitive distortions
- Coping skills
  - Distress Tolerance
  - Grounding/Mindfulness
  - Self care
  - Boundaries

Importance of Resiliency

- **Resilience** is the capacity to adapt to stress and restore homeostatic balance efficiently.
  - Some transient stress is expected and important
- **Post traumatic Growth** positive adaptation to traumatic stress and adversity. Change occurs in 3 domains
  - **Sense of self**
  - **Relationships (others)**
  - **Philosophy of life**

Watson et al. Psychiatric Times May 2013

Establishing Safety: Suggestions for clinicians:

Avoid Retraumatizing -Keep trauma details to a minimum especially during initial assessment.

Empower the client with empathy and collaborative approach. Ask permission when appropriate "would you like to hear some feedback?"

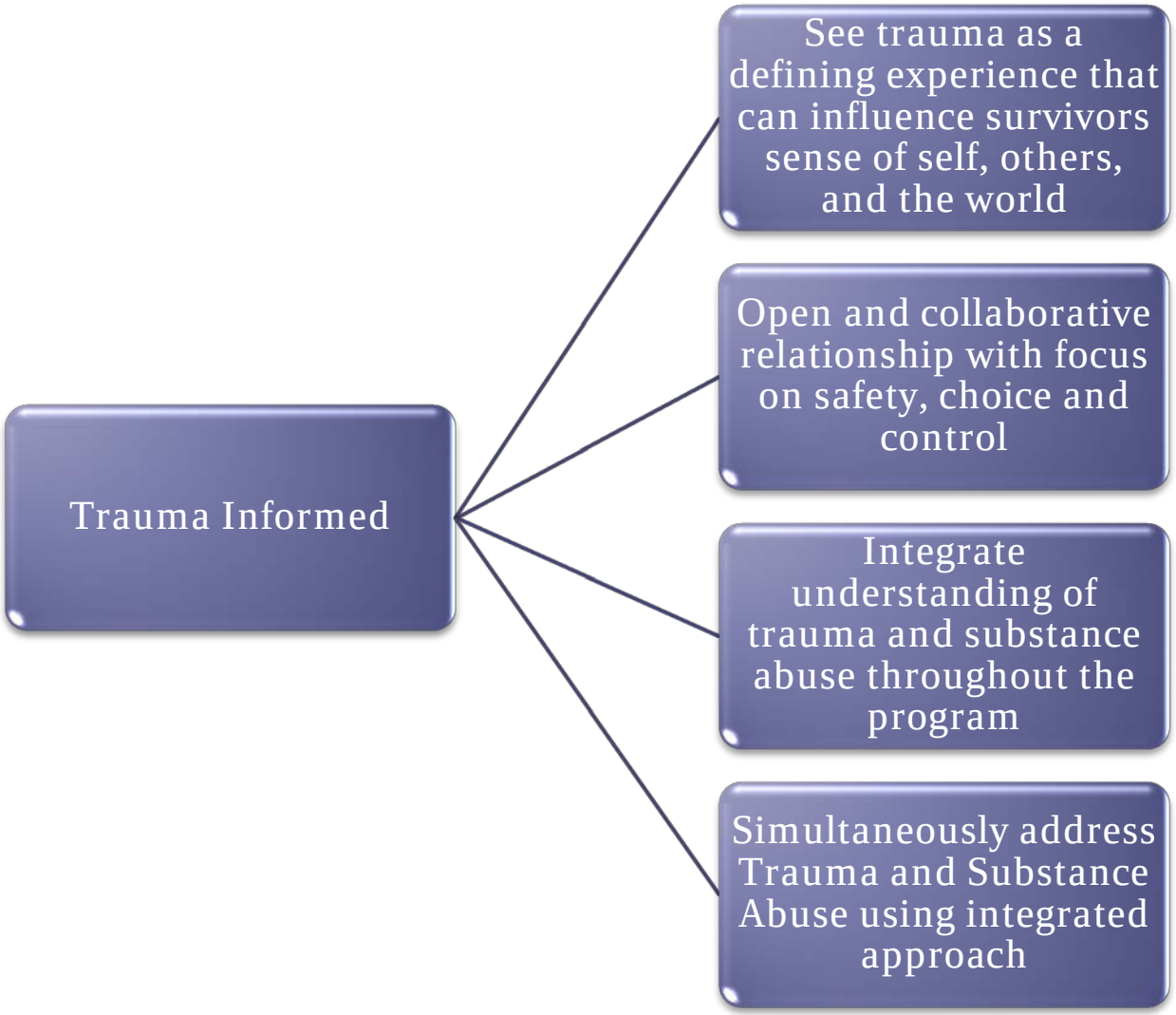
Offer **Choice** when appropriate.

Balance support and accountability

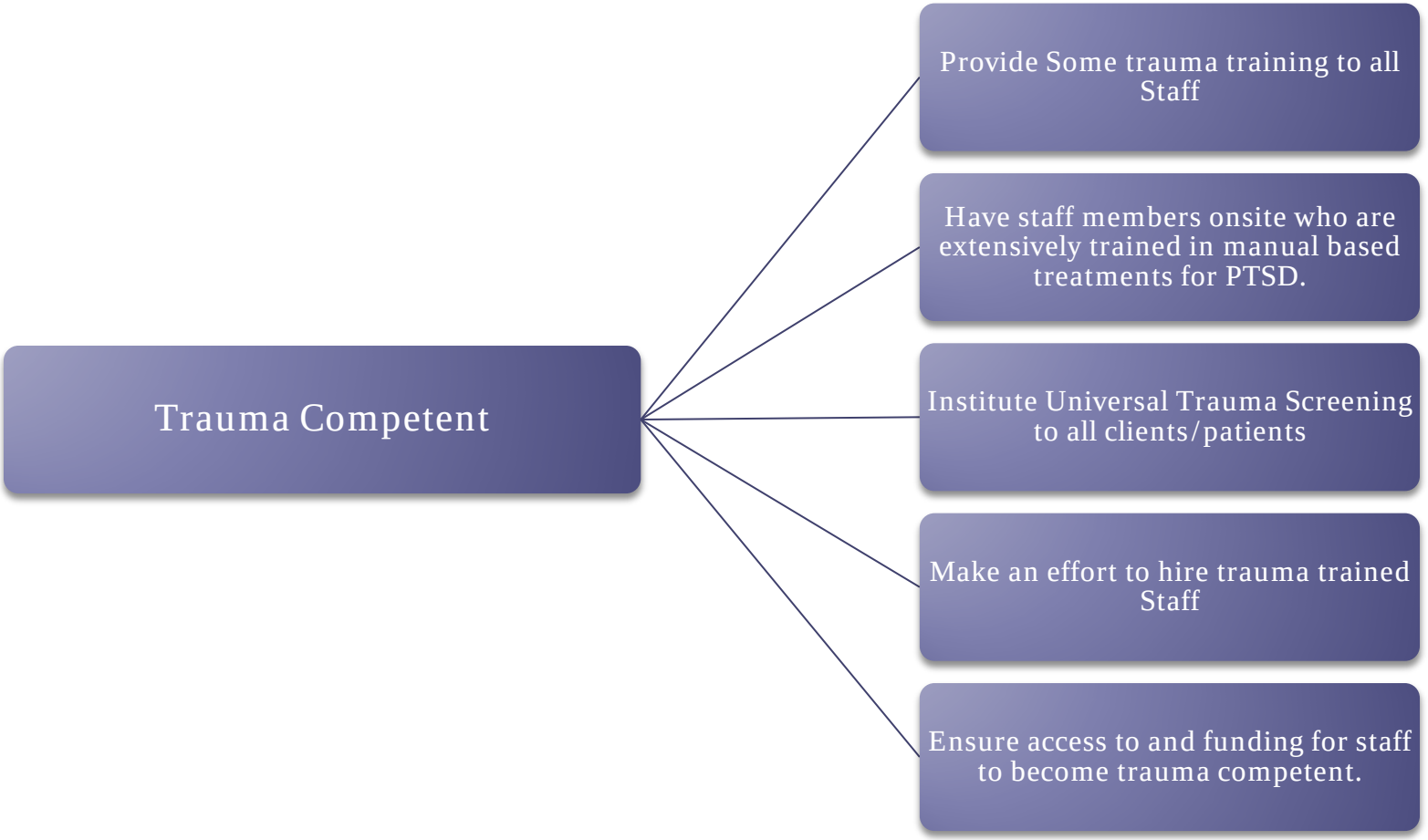
Educate yourself about trauma: statistics, treatment, prognosis.

Najavits, LM 2006 Journal of Chemical Dependency Treatment

“Trauma Informed”Treatment Environment



“Trauma Competent” Treatment Environment.



Self-care and Establishing boundaries is critical when working with trauma and addiction

Clinician Self Care

Self-care and Establishing boundaries is critical when working with trauma:

- **Vicarious Traumatization**- Clinicians can develop symptoms of PTSD by hearing about trauma.
  - Can affect clinical judgment and personal distress
  - Brady et al. 1999 1000 female psychotherapists those with highest level of sexual abuse exposure had highest symptoms
  - Spirituality offered some protection.

Brady et al. Vicarious Traumatization spirituality and the the treatment of sexual abuse survivors Professional Psychology Research and Practice 30 386-393

Warning signs of "Burnout"

Poor boundaries- thinking about work at home, taking on only trauma cases.	Trying to "do it alone" without supervision or team approach.	Sleep disturbance, Lack of exercise and poor self care.	Increased caretaking role in and out of work.	Lack of social support- no friends, family.	Poor spiritual health

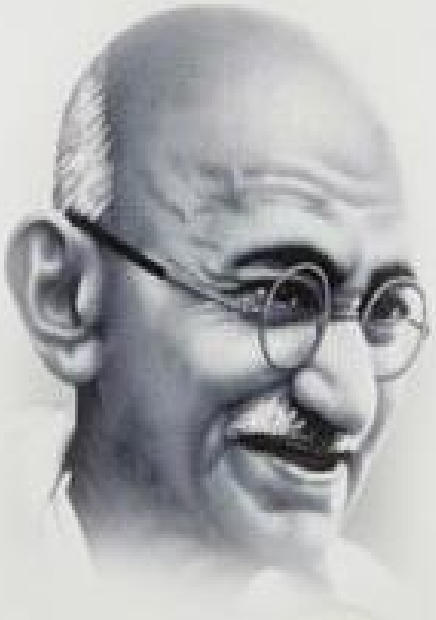
Kendall-Tackett Treating Lifetime Effects of Childhood Victimization 2013

Talbott's Trauma Track

- 8 sessions 1.5 hours weekly
- Mixed gender group
- Available to inpatients who have an identified trauma history
- 2 trauma competent facilitators
- Present centered
- Education and Coping skills driven
- Homework assigned each session
- Focus on Empowerment and Resilience
- Concurrent with individual therapy encouraged

Trauma Group Topics by Session

1. Estabishing Safety
2. Trauma and PTSD Symptoms
3. Long term impacts of PTSD and Substance Abuse
4. Recovery Thinking and Behavior
5. Handling Difficult Emotions
6. The importance Boundaries
7. Maintaining Healthy Relationships
8. Victim or Survivor? Importance of Resiliency



"Be the change you want to see in the world.

- Mahatma Gandhi