Trauma, Resilience & Recovery

Prompting Dialogue

- Impact of trauma on persons in criminal justice systems
- Types of trauma
- Relationship between trauma, substance use and mental health
- Retraumatization
- Impact of trauma on behavior
- Physiological responses to trauma-its impact on health, recovery and wellness
- Clinician wellness

From Maryland's Trauma, Addictions, Mental Health, and Recovery Project: Hypothesis

- Prolonged traumatic experiences may result in maladaptive, risky behaviors that result in incarceration. This sequence is likely to repeat itself unless the needs of the person with the trauma history are met and staff are knowledgeable about the effects of trauma.

Trauma is a universal experience for people living with behavioral health concerns.

People with behavioral health concerns are more likely to experience trauma that is interpersonal, intentional, prolonged/repeated, occurring in childhood and adolescence, and may extend over a lifetime.

- Many ethnic and racial groups have been negatively impacted by historical trauma as well as intergenerational cycles of violence and substance abuse.
- Trauma histories among recipients of behavioral health care largely go unaddressed.
- Left unaddressed, trauma poses dire consequences to the recovery and well-being of the person, families and communities.

What can trauma do?

- Shape a child's beliefs about identity, world view and spirituality
- These negative beliefs require adaptations
- The symptoms ARE the adaptations

The Developing Brain

- Brainstem-controls heart rate, body temperature
- Brainstem also stores anxiety/arousal (body memory) related to trauma

To adapt to trauma, the child uses a “fight or flight” (hyperarousal) response and/or a dissociative response

Read Bruce Perry document

Hyperarousal Response

- What will you see?

Defiance (this is not willful opposition)
Resistance Hypervigilance
Aggression Panic Tachycardia

They are locked in a persistent “fight or flight” state.

More common in older children and males

Disassociation

- What will you see?

Avoidance Withdrawal
Introversion Compliant
Robotic Self-soothing (i.e. rocking)
Fainting

More common in young children, females

The very adaptive responses that help the child survive and cope also put the child at a disadvantage in the classroom or playground.

-these children escalate to a state of fear very quickly

Fear changes the way we think

In a state of fear, the lower, more primitive part of the brain is used-As fear goes up, less thoughtful and more reactive responses occur.

Consequences of trauma

Faulty Control

*Over-control
*Self-blame
*Passivity
*Addictive behavior
*Self-harm

Impaired attachments

*Warmth by friction

*Interpersonal skill deficits

Individuals who have experienced trauma and have been diagnosed with behavioral health disorders are also excluded from their families and society because of the secrets they have to keep, the experiences they have had, their feelings of fear, isolation, shame guilt, blame, unworthiness, etc.

"Many providers may assume that abuse experiences are additional problems for the person, rather than the central problem…"

(Hodas, 2004)

Impact of Trauma Over the Life Span

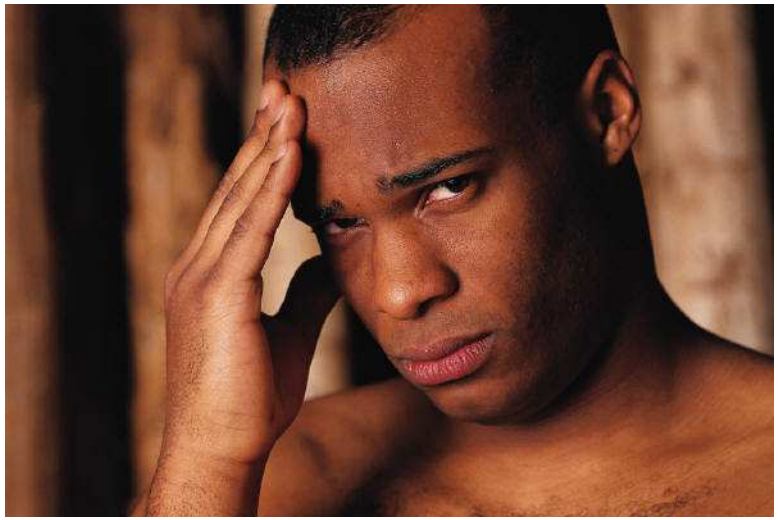
- Effects are neurological, biological, psychological, and social in nature, including:
  - **Changes in brain neurobiology**
  - Social, emotional, and cognitive impairment
  - Adoption of high risk behaviors as coping mechanisms (eating disorders, tobacco use, risky substance use, self harm, sexual promiscuity, violence)
  - Severe and persistent behavioral health, health and social problems, and early death

(Felitti et al. (ACE Study), 1998; Herman, 1992)

Child abuse: Migraine and Comorbid Pain Conditions

- Review article by Kristina Fiore

Abuse-chronic stress-glandular dysregulation-chronic pain



- Break into groups of 6-8.
- Choose someone to scribe
- Discuss what you would expect to see (and perhaps do see) in systems that are not sensitive to trauma

Systems Without Trauma Sensitivity

- Individuals are labeled and pathologized as manipulative, needy, attention-seeking
- Misuse or overuse of displays of power—keys, security, demeanor
- Culture of secrecy—no advocates, poor monitoring of staff
- Staff believe key role is as rule enforcers

Systems Without Trauma Sensitivity (Cont'd)

- Little use of least restrictive interventions other than medication
- Institutions that emphasize "compliance" rather than collaboration
- Institutions that disempower and devalue staff who then "pass on" that disrespect to service recipients

What Trauma-Informed Services Are Not!

- Agency-centered/focused
- Break folks down to build them up
- Condescending
- Demeaning
- Forced treatment
- No consumer involvement

NOT…

- ✓ **A power struggle**
- ✓ **Punitive**
- ✓ **Shaming and blaming**

- Join your group again!!!

- Develop a public service ad that assures those seeking your service, that you are providing trauma-informed, trauma-sensitive care. How will you convey this message?

Definition of Trauma-Informed Care

- Treatment that incorporates:
  - An appreciation for the high prevalence of traumatic experiences in persons who receive behavioral health services.
  - A thorough understanding of the **profound neurological, biological, psychological, and social effects** of trauma and violence on the individual.
  - The care addresses these effects, and is collaborative, supportive, and skill-based.

(Jennings, 2004)

Trauma-Informed Care Systems
Key Features

- ***Presume that every person in a treatment setting has been exposed to abuse, violence, neglect, or other traumatic experiences.***

- Early and thoughtful diagnostic evaluation with focused consideration of trauma in people with **complex illness who have been most challenging to engage into services**

Trauma-Informed Care Systems
Key Features (Cont'd)

- Recognition that service environments are often traumatizing, both overtly and covertly

i.e. In prisons:

Violence, rape, molestation, intimidation between inmates/between corrections staff and inmates, staff personalization of/reactivity to inmate behavior

*Read page 8, People in the Criminal Justice...

Ruta Mazelis, 2003

*Read Laura Prescott, 2009

- Recognition that the majority of staff are uninformed about trauma and its sequelae, do not recognize it, and do not treat it

Trauma-Informed Care Systems
Key Features (Cont'd)

- Valuing the individual in all aspects of care
- Neutral, objective, and supportive language
- Individually flexible (person centered) plans and approaches
- Avoid shaming or humiliation at all times

Trauma-Informed Care Systems
Key Features (Cont'd)

- Focusing on what happened to you in place of what is wrong with you *(Bloom, 2002)*
- Asking questions about current abuse
  - Addressing the current risk and developing a safety plan for discharge
- One person sensitively asking the questions

Trauma informed services are:

- Consumer-driven
- Informative
- Hopeful
- Safe
- Nurturing
- Trust-building

AND…

- Respectful
- Empowering
- Based on secure attachments
- Person-centered
- Individualized
- Flexible

- No power struggles
- No mandates or absolutes
- Collaborations and consensus
- Building self-esteem
- The “whole truth”

- ***Those receiving services are the experts on their experiences.***

The professional is the expert who guides and supports using concepts, theories, and techniques.

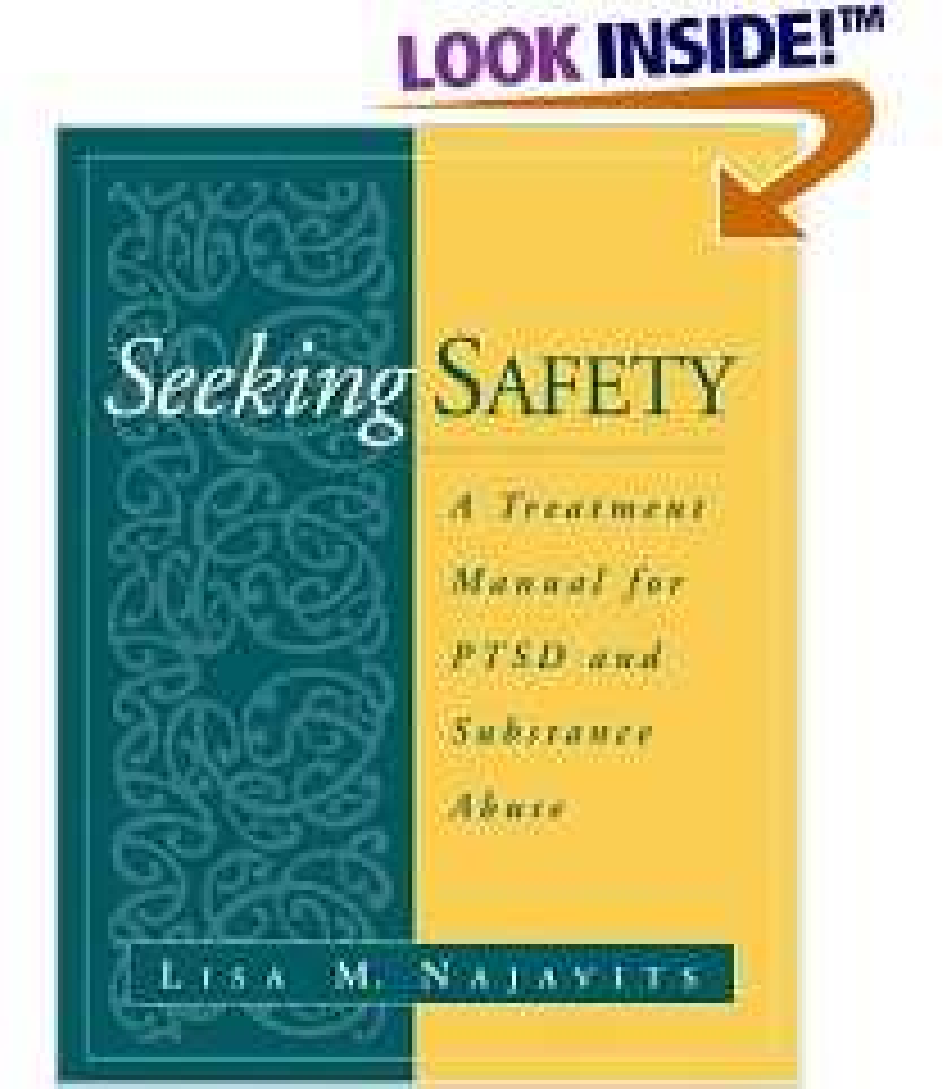
Together they can form a roadmap for change!

Boston Consortium Model

- Trauma informed substance use treatment for women
- Read SAMHSA's NREPP

T.A.M.A.R.

Seeking Safety (Najavits, 2002)
A Cognitive Behavioral Treatment



Seeking Safety-cont'd

- 24 sessions that teach women new coping skills to manage PTSD and SUD at once.

- Learn how to ask for help, set boundaries in relationships, nurture themselves, and fight cues and urges to relapse to drug use.

Trauma-Behavioral Health

Those in Mental Health services: 40%-60% experienced childhood trauma

Those in Substance Use services:

-60%-70% of women experienced childhood trauma

-60% of men experienced physical assault

-33% of men experienced childhood sexual abuse

Experience of Trauma in Youth Involved in the Justice System

- Childhood abuse or neglect increases the likelihood of arrest as a juvenile by 53 percent and as a young adult by 38 percent—the likelihood of arrest for a violent crime also increases by 38 percent.

  (NASMHPD/NTAC, 2004)

- Prevalence of PTSD in DJJ populations is eight times as high as a community sample of similar peers.

  (Wolpaw & Ford, 2004)

- Among a sample of juvenile detainees more males (93 percent) than females (84 percent) reported experiencing trauma; however, more females met PTSD criteria (18 percent females vs. 11 percent males).

  (Abram et al., 2004)

National Child Traumatic Stress Network (NCTSN)

NCTSN's Subcommittee on Juvenile Justice working group reported the following:

- Boys in the juvenile justice system report trauma in the form of witnessing violence—girls are likely to report being the victim of violence. *(Steiner et al., 1997)*

- 74 percent of juvenile justice–involved females report being hurt or in danger of being hurt; 60 percent reported being raped or in danger of being raped; 76 percent reported witnessing someone being severely injured or killed. *(Cauffman et al., 1998)*

- Childhood abuse and/or neglect increases the risk of promiscuity, prostitution, and pregnancy. *(Wisdon & Kuhns, 1996)*

How trauma is being described…

- Type I: Short-term, unexpected event such as one time rape, car accident, natural disaster

- Type II: Complex trauma with sustained, repeated ordeal stressors such as ongoing physical/sexual abuse

Key to Trauma-Event Response

THE KEY

- The response to the event involves intense fear, helplessness, or horror

Prevalence of Trauma Disorders

- 3.5% of adults have PTSD in a given year (NIMH, 2006)
- 5% of men and 10% of women have had PTSD in their lifetime (Kessler, et al., 1995)
- Women are twice as likely to develop PTSD as men (NIMH, 2001)

Factors that influence trauma response

- Personality prior to trauma
- Mental health status
- Severity of the trauma (actual and perceived)
- Social support following trauma
- Crisis intervention
- Response of others to the trauma (family, friends, co-workers, society)

Type II Trauma is…

- More likely to result in long-standing personality and interpersonal problems, dissociation, **substance use disorders**

Type II Complex Trauma

- Difficulty in regulating emotional arousal

-chronic mood disorders

-difficulty with anger

-self-destructive and suicidal behavior

-impulsive and risk taking behaviors (sex, **substance use** etc)

Type II Complex Trauma

Alterations in Attention and Consciousness

-dissociation, amnesia

Chronic Character Changes

-guilt and shame, sees self as ineffective and permanently damaged

- Approaches life with “When I am going to get hurt” vs. “If I am going to get hurt”

- Core beliefs:

“I am a mistake”

“I am bad”

“I am ineffective”

Type II Complex Trauma

- Change in perception of the perpetrator(s) such as idealizing the perpetrator
- Change in perception of others

-Inability to trust or maintain relationships

-Tendency to be revictimized

-Tendency to victimize others

Type II Complex Trauma

- Change in hope and belief system

-despair, hopelessness

Thinking About Trauma…

- *Trying to regulate feelings/mood*

- ***Substance use***
- *Self-harm (e.g. cutting, burns)*
- *Other compulsive behavior (e.g. sexual acting out)*
- *Excessive sensation seeking/risk taking*
- *Dissociation*

An Example of Functional Analysis

Example

- *Be good/perfect (childhood beliefs)*
- *Pressure builds, ending in agitation*
- *Tired of "being good"*
- *Lonely, bored*
- *Drinks and does "wild things"*
- *Feels ashamed, dirty (childhood feelings)*

Symptom & Trigger Relationships

Trigger

Anxiety
Shame

Drug Use
Self-Harm
Dissociation
Sexual Acting Out

Impairment

Relationship Between Trauma and Addiction-the following slides adapted from

Shelly A. Wiechelt PhD., LCSW-C, CCDC

Research consistently shows significant similarity between rates of PTSD and SUD (Substance Use Disorder) in both community and clinical samples (Chilcoat & Menard, 2003; Stewart & Conrod, 2003)

- Research shows a relationship between trauma and substance use disorders

Some Facts to Ponder

- 70% of women with drug use disorder report that they were sexually abused before age 16
- 34%-77% of women with alcohol use disorder have experienced childhood sexual abuse
- 65% of women with alcohol use disorder experienced severe physical violence in childhood

Fact cont'd

- Women who experience domestic violence may use substances in an effort to cope (Miller, 1998)
- Vietnam war vets with PTSD were 6x more likely to have drug use disorders than those without PTSD (Kulka, et al., 1990)

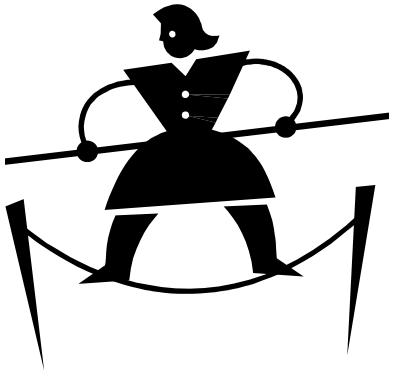
Self Medication Hypothesis
Trauma First

- Substances are used to reduce or control psychological suffering and painful emotions (Khantzian, 1985; 2000; 2003)

- SUD occurs as the result of attempts to self-medicate PTSD or trauma symptoms with substances

High-Risk Hypothesis
Trauma After

- “Drug use is a high-risk behavior that increases individuals’ risk of exposure to trauma” (Chilicoat & Menard, 2003)



Susceptibility Hypothesis

- Drug users become more susceptible to PTSD following trauma exposure (Chilicoat & Menard, 2003)

Functional Relationship Between Trauma and SUD

- Regardless of “which came first”, once both disorders are present, the symptoms of each disorder work to maintain each other…a vicious cycle!

Treatment-What to do?

- Clinicians tend to treat what they know
- Addiction professionals often want to treat the addiction and wait to treat the trauma
- Trauma focused professionals tend to believe that the substance use disorder will remit when the trauma symptoms are reduced

How does trauma affect substance use recovery?

- Overwhelming emotions (previously blunted by substances)
- Boundary problems
- Relationship problems (e.g. trust, fear)
- Increased PTSD symptoms
- Job problems
- Lapses

How does substance use affect trauma treatment?

- Continued substance use
- Continued high risk behavior
- Unable to alleviate PTSD symptoms
- Vicious cycle

What are the choices?

- Sequential treatment-first one disorder, then the other
- Parallel treatment-at the same time with different clinicians/programs
- Integrated treatment-at the same time with the same clinician or program

How it is: Trauma Care Within Substance Use Services

- Barriers within the agencies and services
- Clinician discomfort
- Concern about what may happen to client

Back in our groups:

What concerns do you have about screening for trauma?

Some Concerns About Trauma Screening in Addiction Services

- Diminishes emotional safety
- It might be too much, too soon
- Might scare clients away (engagement and retention have been serious concerns for substance use providers)
- May trigger traumatic memories
- May not be enough support to cope (especially outpatient services)

Concerns cont’d

- May increase risk for relapse
- Clinicians have not been trained to handle trauma
- Philosophy of some addiction counselors and their agencies do not support addressing trauma
- Without adequate training, may traumatize client again
- Limited time when doing substance use evaluation

How can we overcome the concerns?

- Provide training for trauma screening (clinicians have already been trained to do mental health screening)
- Provide effective supervision
- Provide staff with effective support for their own wellness; they are being exposed to the trauma of others

Overcoming…cont'd

- Match clients to clinicians who can meet their needs
- Provide gender specific groups (this has historically been done by many providers of substance use services-did we understand how trauma influenced this action?)
- Screen for trauma AFTER

  rapport established

Overcoming…cont'd

- Allow enough time for evaluation (for building therapeutic relationship, safety)

- Develop appropriate interventions/referrals

The Evaluation-How to fit the puzzle pieces together

Include trauma history questions into the bio-psycho-social

Keep environment safe (both physical and psychological)

THE CLIENT DECIDES WHAT TO SHARE AND HOW MUCH TO SHARE

Consider providing same gender counselor

So What Does the Counselor Do…

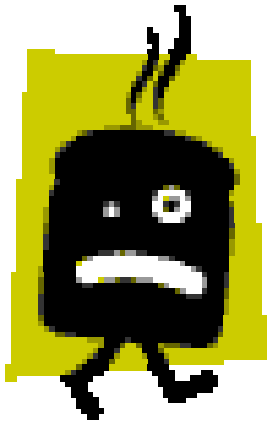
- Be a welcome listener
- Maintain safety
- Demonstrate honest responses (to stories of trauma)
- Don’t seek more information that you are prepared to handle
- Work through your own issues
- Maintain physical and psychological boundaries
- Focus on the client’s strengths (resiliency)

What Can Realistically Be Done During Addiction Treatment

- Psychoeducation
- Social Skills Training
- Support, support, support
- When adequately trained and supervised- Trauma Focused Therapy

Vicarious Trauma

- Family dynamics from your past can increase your vulnerability to “BURNOUT”



- Did your parents make if difficult for you to think for yourself?

- Were your parents overcritical and over demanding?

- If you are a woman, did your mother behave as though she was less important than your father?

- Did your mother or father have a substance use or mental health disorder?

- Was either parent distant, non communicative or lacking in affection?

- Were you ashamed of either or both of your parents?

- Were you in competition with any of your siblings?

- Were you a child who was thrust into an adult role prematurely?

- Did you feel compelled to keep your aspirations a secret?

- Were you rarely allowed any privacy?

- Were you reluctant to expose any feelings of hurt, disappointment or sadness in front of your parents?

- Were you left alone to care for yourself and, as a result, did you impose your own strict set of criticisms on yourself?

- Were you ever talked about as being awkward, lazy, stupid, or inept?

- When you wanted something for yourself, were you accused of being selfish and self-centered?

- Did you feel guilty over being brighter than other members of your family, and did you hide your intelligence?

- Were you never seen as “good” enough?

- Did you develop a false front to cover your true feelings?

- Did either parent insist you do everything “his/her” way?

What you bring to the therapeutic relationship

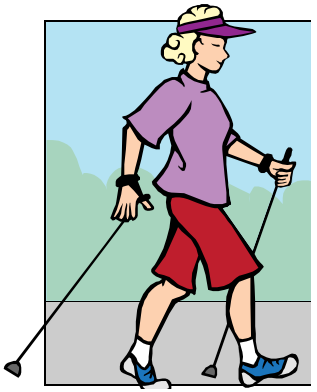
Understanding how your family interacted with each other, how that affected you and how it impacts your world view today...

Building Resilience (D. Charney, M.D.)

- Be optimistic-can be learned through CBT
- Develop cognitive flexibility-ability to "adapt" knowledge
- Develop a moral code or set of beliefs
- Be altruistic
- Find a resilient role model/mentor

- Learn to be adept at facing your fears (extinction, stress inoculation)
- Develop active coping skills
- Establish and nurture a supportive social network (during times of stress, emotional strength comes from close, meaningful relationships)

- Keep fit



- Have a sense of humor and laugh frequently

Thanks for your participation

Special thanks to the University of Buffalo and the Trauma Certification Program