Welcome to CAMH in the Community

PROVIDING TRAUMA INFORMED ADDICTION & MENTAL HEALTH CARE
Centre for Addiction and Mental Health in partnership with the Waterloo Wellington Local Health Integration Network (WWLHIN) and the Waterloo Wellington Addiction and Mental Health Network present:

PROVIDING TRAUMA INFORMED ADDICTION & MENTAL HEALTH CARE

1:00 – 1:20 p.m. Welcome and Introductions - Centre for Addiction & Mental Health
Greetings from Patricia Syms Sutherland, Senior Manager – Health System Transformation Waterloo Wellington LHIN

1:20 – 2:30 p.m. Dr. Pamela Stewart
Head of the Trauma and Addictions Clinic, CAMH

2:30 – 2:45 p.m. Break

2:45 – 3:30 p.m. Dr. Pamela Stewart (continued)

3:30 – 3:50 p.m. Question and Answer

3:50 – 4:00 p.m. Closing
Providing Trauma Informed Addiction & Mental Health

June 9, 2011

Faculty: Pamela Stewart, M.D.
WORKSHOP OBJECTIVES

• To understand the prevalence and etiology of trauma and substance use disorders
• To understand some of the underlying common cognitive beliefs perpetuating these disorders
• To identify the functional relationship between trauma & addiction
• Describe the various stages of trauma
• To summarize the best practice recommendations, and evidence-based models for Stage 1 trauma & substance use treatment
• To review Seeking Safety Model
Overview of Definitions

A review
So what does ‘Trauma-Informed’ mean?

‘Trauma-Informed Service’:
Defined as particular treatment models (i.e. services that might be offered, or modified) to be responsive to the impacts of trauma.

Vs. ‘Trauma-Informed Treatment’:
Defined as incorporating the broader backdrop of: clinical, agency, community and provincial/national structures that enable clinicians/programs to adapt their methods so as to influence a woman’s access to treatment, and her care.

(FROM: Hien et al in, Trauma Services for Women in Substance Abuse Treatment, (2009).)
Now what does that mean for your practice re: competencies?

A ‘trauma-informed clinician’ is one who is:

1. Informed about the **prevalence** of trauma in their client population
2. Informed about the **effects** of psychological trauma
3. **Able to assess** for the presence of symptoms/problems related to that trauma
4. **Able to validate** the client’s experience of trauma, and how it **links** to their addictive behavior
5. **Able to offer service to facilitate recovery**; and if not, to **recognize what is outside** their scope of practice, and make the appropriate referral
DSM IV: Defining ‘PTSD’

- PTSD is classified as one of the 10 anxiety disorders in the DSM-IV

- PTSD should not be confused with normal grief and adjustment after traumatic events.
DSM IV: Defining ‘PTSD’

PTSD is a diagnostic term for a psychiatric condition wherein the person has been exposed to a traumatic event in which both of the following are present:

(1) The person experienced, witnessed, or was confronted with an event (or events) that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others

(2) The person’s response involved intense fear, helplessness or horror.
NOTE: It is possible for individuals to experience traumatic stress without developing PTSD;

In fact, most people who experience traumatic events will not develop PTSD:

- For most people, the emotional effects of the traumatic event(s) tend to subside after several months.
Experiences which may induce ‘PTSD’

• Childhood physical, emotional, or sexual abuse, including prolonged or extreme neglect; also, witnessing such abuse inflicted on another child or an adult

• Experiencing an event perceived as life-threatening, such as:
  – a serious accident,
  • medical complications
  • violent physical assaults or surviving or witnessing a such an event, including torture
  • adult experiences of sexual assault or rape
  • warfare
  • violent, life threatening, natural disasters
  • incarceration
DSM IV: PTSD Symptoms

PTSD symptoms can include the following:

- Nightmares
- Flashbacks
- Emotional detachment or numbing of feelings (or dissociation)
- Insomnia
- Avoidance of reminders and extreme distress when exposed to the reminders ("triggers")
- Loss of appetite
- Irritability
- Hyper vigilance
- Memory loss (may appear as difficulty paying attention)
- Excessive startle response
- Clinical depression
- Anxiety
So trauma is ‘context-driven’
PTSD: 3 Cluster Symptom Triad

**INTRUSION/RE-EXPERIENCING**
- Distressing memories
- Recurrent dreams of event
- Intense distress to internal/external cues

**AVOIDANCE**
- Feelings
- Thoughts
- Activities
- Places
- People
- Detachment
- Inability to recall significant parts of memory
- Restricted range of affect

**INCREASED AROUSAL**
- Difficulty falling asleep (or staying asleep)
- Irritability or anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

Most prominent PTSD cluster in PTSD was arousal followed by avoidance (Najavits, 2003)
PTSD: 3 Cluster Symptom Triad

**AVOIDANCE**

**INTRUSION/RE-EXPERIENCING**

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**Active Avoidance**

- Affective
  - Numbing/Emotional
  - Avoidance
PTSD: 3 Cluster Symptom Triad

**INTRUSION/RE-EXPERIENCING**
- Distressing memories
- Recurrent dreams of event
- Intense distress to internal/external cues

**AVOIDANCE**
- Difficulty falling asleep (or staying asleep)
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- Difficulty concentrating
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- Exaggerated startle response

**EMOTIONAL AVOIDANCE**
- Anger
- Guilt
- Shame

**ACTIVE AVOIDANCE**
- Examples: Distressing memories, recurrent dreams of event, intense distress to internal/external cues
1st Cluster: Intrusion/Re-experiencing

- Since trauma sufferers are unable to process the extreme emotions brought about by the trauma, they are plagued by the intrusion of recurrent nightmares or daytime flashbacks, during which they graphically re-experience the trauma.

- These re-experiences are characterized by high anxiety levels.
2nd Cluster: Hyperarousal

- PTSD is also characterized by a state of nervousness and preparation for "fight or flight".

- Hyperarousal is the typical hyperactive startle reaction, characterized by "jumpiness" in connection with high sounds or fast motions.
3rd Cluster: Avoidance/Numbing

• The hyperarousal and the intrusive symptoms are eventually so distressing that the individual strives to avoid contact with everything and everyone, even their own thoughts, which may arouse memories of the trauma; and thus, provoke the intrusive and hyperarousal states.

• The sufferers isolate themselves, becoming detached in their feelings with a restricted range of emotional response and can experience so-called emotional detachment ("numbing").
Cluster Considerations

- Attempts to alleviate Intrusive and Hyperarousal symptoms may drive the substance use of many of these clients.

- Clients’ reliance on Avoidance coping may partially explain the relationship between PTSD and poorer substance use outcomes.

- SUD-PTSD patients with more severe intrusive and hyperarousal symptoms, poorer coping skills and more psychiatric comorbidities may be at higher risk for relapse.
Dissociation is another ‘defence’ that includes a variety of symptoms including:

- feelings of depersonalization and derealization
- disconnection between memory and affect so that the person is ‘in another world’
- in extreme forms, can involve apparent multiple personalities and acting without any memory ("losing time").
Defining ‘Complex PTSD’

C-PTSD is a clinically-recognized syndrome that results from exposure to prolonged and repeated interpersonal trauma such as:

- physical abuse
- emotional abuse
- sexual abuse
- domestic violence
- torture
- chronic early maltreatment in a caregiving relationship,
- and war
‘Complex PTSD’ (cont’d)

According to van der Kolk and Courtois (2005), Complex PTSD better describes the pervasive negative impact of chronic trauma, than does the diagnosis PTSD.

PTSD fails to capture C-PTSD sufferers’:
- loss of sense of safety, trust, and self-worth,
- their tendency to be re-victimized,
- and their loss of a coherent sense of self.
- C-PTSD is under consideration for inclusion in the next revision of the (DSM-V) as a formal, coded diagnosis.
‘Complex PTSD’ Symptoms

C-PTSD is characterized by chronic difficulties in many areas of emotional and interpersonal functioning. Symptoms include:

- Difficulties regulating emotions, including symptoms such as persistent sadness, suicidal thoughts, explosive anger, or inhibited anger
- Variations in consciousness, such as forgetting traumatic events, reliving traumatic events, or having episodes of dissociation (during which one feels detached from one's mental processes or body)
- Changes in self-perception, such as a sense of helplessness, shame, guilt, stigma, and a sense of being completely different from other human beings
‘Complex PTSD’ Symptoms (cont’d)

- Varied changes in the perception of the perpetrator, such as attributing total power to the perpetrator or becoming preoccupied with the relationship to the perpetrator, including a preoccupation with revenge

- Alterations in relations with others, including isolation, distrust, or a repeated search for a rescuer

- Loss of, or changes in, one's system of meanings, which may include a loss of sustaining faith or a sense of hopelessness and despair
‘Complex PTSD’ Symptoms (cont’d)

- **Behavioral control** - poor modulation of impulses, self-destructive behaviour, aggressive behaviour, sleep disturbances, eating disorders, substance
- **Dissociation** - distinct alterations in states of consciousness, amnesia, depersonalization and derealization abuse, oppositional behaviour, excessive compliance
- **Cognition** - difficulties in attention regulation and executive functioning, problems focusing on and completing tasks, difficulty planning and anticipating, learning difficulties, problems with language development
- **Self-concept** - lack of a continuous and predictable sense of self, low self-esteem, feelings of shame and guilt, generalized sense of being ineffective in dealing with one's environment, belief that one has been permanently damaged by the trauma
“The past isn’t dead- it isn’t even past”

-William Faulkner
Refresher: ‘Substance Abuse’:
(At least one must apply for at least 1 month, within the past year)

1. Recurrent use leads to **failure to fulfill major role obligations** at work, school, or home
2. Recurrent use in situations which are **physically hazardous**
3. Recurrent **substance-related legal problems**
4. Continued use despite **persistent physical, social, occupational, or psychological problems** caused or exacerbated by its use

NOTE: Does NOT meet criteria for ‘Substance Dependence’
Refresher: ‘Substance Dependence’:
(A maladaptive pattern of use, causing impairment as manifested by at least 3 of the 7 criteria, within a 12-mo. period)

1. Preoccupation with substance
   – drug seeking/drug-taking/recovery from effects
2. Tolerance
3. Withdrawal
4. Use over a longer period, or more of substance, than intended
5. Persistent desire or unsuccessful efforts to control drug use
6. Reduction or abandonment of important social, occupational or recreational activities
7. Continued drug use despite major drug-related problems
Epidemiology (Co-Prevalence Stats from the Major Studies)
Prevalence of PTSD

In the general population:

• 39-74% are exposed to trauma (situations which could involve death, injury, or severe damage to oneself or a loved one’s personal integrity) (Norris, 1992)

• However, only 9.3-12.3% of people develop PTSD as a result of their trauma (Kessler, 1995)
Rates of Comorbid PTSD & SUD
(in the major ‘community’ samples)

(1) Cottler et al. (1992) (used ECA Survey (Regier et al) sample of 2943 participants):
• The lifetime prevalence for substance use disorder among people with a history of PTSD was found to be 30%-75%

(2) National Comorbidity Survey (Kessler et al, 1995) used DSM-III-R (sample of 5877):
• Range: 65.1% - 84.3% in women
• Range: 52.7% – 62.5% in men
  - Note: PTSD preceded SUD in the majority of cases
Comorbidity of PTSD & SUD
(in ‘Substance Abusing’ samples)

In substance abuse samples
(Brady et al, 2001; Jacobsen et al, 2001; Najavits et al, 1997):

• ‘Lifetime’ rates of PTSD range from 30-75%
• ‘Current’ rates range from 12%-62%
• 20-33% of patients with SUD seeking treatment meet criteria for current PTSD
(Back et al, 2000; Brown, Recupero, & Stout 1995; Najavits et al, 1998; Triffleman, Marmar, Delucchi & Ronfeldt, 1995)
Co-Prevalence in the AP

Data from CAAP (2008-09) (n=1547):

- 54.8% Clients who report having experienced any form of trauma (physical, sexual and/or emotional) in their lifetime
- 48.6% Clients reporting that they use substances to cope with past or current issues, feelings, memories (flashbacks or nightmares) related to physical/sexual/or emotional trauma

What staff perceive from: 'CD Capable Survey' (2009):

- 23.9% of AP staff felt Trauma/PTSD was the most common psychiatric problem on their caseloads.
Gender Differences
Gender Differences

- Women are more likely than men to have a history of trauma
- While the rate of PTSD among people receiving substance use treatment is 12-34%;
- The rate jumps to 86-90% among women (Najavits, 2002); therefore, women are at increased risk of developing concurrent disorders (Baird, 2008; Baker & Velleman, 2007).
Gender Considerations: Women (Cont’d)

• Women tend to report greater exposure to:
  – Childhood Sexual Abuse
  – and adult sexual victimization

• Women experience greater frequency and avoidance of:
  – trauma-related thoughts and feelings
  – and greater social impairment due to PTSD

• Women are more likely to demonstrate higher rates of other anxiety disorders, and may be more likely to abuse other substances (e.g. cocaine and benzodiazepines)
Prognostic Considerations...

- PTSD renders clients with SUD more vulnerable to poorer short- and long-term treatment outcomes.

- Clients with CD PTSD & SUD compared to those with PTSD or SUD alone show higher rates of:
  - Axis I and II disorders
  - psychosocial problems
  - inpatient substance abuse treatment admissions
  - and medical course

Prognostic Considerations (cont’d)...

Other areas of difficulty include:

- Shame
- Aggression and narcissistic rage
- Avoidance of feelings of vulnerability
- Powerlessness
- Stigmatization
- Frequent relapses
- Poor treatment compliance
- High rates of self-mutilation
- and eating disorders
Summary

• A history of trauma often results in impairments to acquisition of adequate coping skills.
• This increases reliance on substance use as means of self-soothing, regulating affect, overall coping.
• Substance use itself is a high-risk lifestyle that increases individuals’ risk of exposure to additional trauma.
• These clients often progress through treatment more slowly, are hospitalized more frequently, and suffer more severe regressions of both illnesses.
TRAUMA RESPONSE

Hyperarousal

Optimum Arousal Zone

Freezing/Numbing
Cognitive Beliefs of Trauma & Substance Use Disorders
Janoff-Bulman (1992): ‘Shattered Assumptions’

CM Parkes: Assumptive world

- Bowlby: “working models” that people build of themselves and the world, which are used to perceive events, construct plans, and forecast the future

- Sandler: “representational world”
Janoff-Bulman (1992)

3 Fundamental Assumptions:

1. The world is benevolent
2. The world is meaningful
3. The self is worthy
(1) The World is Benevolent…

In considering the benevolence of “the world”, people are actually considering the benevolence of their world
(2) The World is Meaningful…

- A Meaningful world: is one in which a ‘self-outcome’ contingency is perceived; there is a relationship between a person and what happens to him/her.

Thornton Wilder in *The Bridge of San Luis Rey*:

- After the great bridge broke and five travelers fell to their death, he asked:
  
  “Why did it happen to those five?”

  …Either we live by accident and die by accident, or we live by plan and die by plan.”
• In western culture, the social laws most likely to be invoked explain the “why” of events are those of justice and control; these enable us to believe that misfortune is not haphazard and arbitrary, that there is a ‘person-outcome’ contingency
(3) Worthiness of the Self...

- Winnicott: Holding environment “good enough mother”

- Kohut: Grandiose sense of self

- Bowlby: Attachment theory (working models of their world)
  “The earliest interactions with sensitive caregivers provide a basis for pre-verbal representations about the world and what the self is like”
Worthiness of the Self (Cont’d)

• The virtual universality of the belief is invulnerability and the feeling that one is secure and protected is made particularly apparent by people’s reactions to their own traumatic life events. Bad things do happen to people; the world is not wholly benevolent and meaningful, and we are not always competent and worthy.
These core beliefs are shattered by Trauma...
Janoff-Bulman (cont’d)

- Survivors of human-induced victimizations are most apt to hold more negative assumptions about themselves and the benevolence of the world.

- In general, for them, these assumptions seem to move in concert:
  - the world is viewed as more malevolent
  - the self is viewed as more malevolent (more negatively, as if one mirrors the other)
Self-Blame

- Reflects adaptive motivations by survivors
- Entails perceptions of the traumatic event that strive to minimize threat to the survivor’s concept of self and the world.
- Survivors are motivated by recovery, not accuracy in attributions.
Two Types of Self-Blame

1. ‘Behavioral’ Self-Blame:
   • Something could have been done to alter the outcome (i.e. “I should not have gone to their house”)
   • Not generalized to the whole person (=positive coping)

2. ‘Characterological’ Self-Blame:
   • Self-Esteem related: “I am a very bad judge of character” (=negative coping)
Briere (1995)

- **Self**: helpless and inadequate
- **Others**: powerful and malignant
- **Environment**: inherently dangerous
## Cognitive Distortions

<table>
<thead>
<tr>
<th>Parent</th>
<th>Perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Either as one who requires obedience/or could not be counted on for protection or safety</td>
<td></td>
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<tr>
<td>• Power as inherently malevolent; survivor’s resultant fear and acquiescence can be reinforced in the therapeutic relationship</td>
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</table>
**Cognitive Distortions (Cont’d)**

<table>
<thead>
<tr>
<th>Rescuer</th>
<th>Lover</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Longed for when the survivor was being abused;</td>
<td></td>
</tr>
<tr>
<td>• Patient assumes a passive role in therapy</td>
<td></td>
</tr>
<tr>
<td>• Inevitable risk of failing to provide a cure, not maintaining complete empathy;</td>
<td></td>
</tr>
<tr>
<td>• becoming devalued as betrayer/abandoner.</td>
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</tbody>
</table>
Karpman’s Triangle

VICTIM

ALLY/BYSTANDER

PERPETRATOR

RESCUER
### General Cognitive Distortions
(adapted by Najavits from Burns)

<table>
<thead>
<tr>
<th>Should’s</th>
<th>You have a list of how the world ‘should’ work. When the rules are violated, you feel angry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focusing on the negative</td>
<td>You magnify all the negatives; ignore all the positives</td>
</tr>
<tr>
<td>All-or-nothing thinking</td>
<td>Things are black/white; good or bad. There is no middle ground</td>
</tr>
<tr>
<td>Feelings are reality</td>
<td>Because you feel something is true; then it must be true</td>
</tr>
</tbody>
</table>
General Cognitive Distortions (Cont’d)

- **Fortune-telling**
  - You think you know what the future might bring, you expect disaster and gloom

- **Mind-reading**
  - You know what other people are thinking without having to ask them

- **Uniqueness Fallacy**
  - You believe you alone have a particular problem; no one else could possibly understand
Cognitive Distortions
Specific to PTSD & SUD
(Najavits, 2004)

<table>
<thead>
<tr>
<th>The escape</th>
<th>You can’t tolerate your feelings or solve your problems, so you must find an escape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beating yourself up</td>
<td>In your mind, you yell at yourself and put yourself down</td>
</tr>
<tr>
<td>Instant satisfaction</td>
<td>You have a right to immediate satisfaction, without waiting or working. Life should be easy</td>
</tr>
<tr>
<td>Rose-coloured glasses</td>
<td>Things will work out perfectly from now on. You have no mixed feelings, no ambivalence, no doubts, no worries about the future</td>
</tr>
</tbody>
</table>
Cognitive Distortions
Specific to PTSD and SUD (Cont’d)

- Dangerous Permission
  - You give yourself permission for self-destructive behavior

- Time Warp
  - It feels like a negative feeling will go on forever

- Short-term thinking
  - You see only what’s directly in front of you. You focus only on the short-term (how you’ll feel in a few minutes) rather than the long-term (how you’ll feel in a few hours, tomorrow, or later in life)
Cognitive Distortions (Cont’d)

- Fooling yourself
  - You trick yourself into believing something is okay when it’s not

- Confusing Needs and Wants
  - You want something very badly, so you assume that you **have to** have it
  - You remember only the wonderful highs from something (a drug, an abusive relationship) but ignore all the pain and tragedy associated with it

- The good ole days

- Overreacting
  - You make a mountain out of a molehill. Things take on “life or death” proportions in your mind, beyond what is rational
Fighting Unworthiness…

“When I find myself feeling unworthy or remembering the messages I received as a child, I must remember I am now in a safe place, away from those who hurt me in the past. No one can hurt me now, unless I let them, what people told me as a child was not my fault, it was their actions and responsibilities irresponsibly placed on me”
Reasons I am Worthy

• I am compassionate

• I love others like I would want to be loved

• I have many friends

• I have empathy for other people and their suffering
Assessing the Relationship of Substance Use Disorders to PTSD
Two primary relationships have been described to explain the high rates of concurrent PTSD and SUDs:

(I) Substance abuse precedes PTSD:
Some substance abusers repetitively place themselves in dangerous situations in order to sustain their habit – and thus, experience high levels of physical & psychological trauma

(II) PTSD precedes development of SUD (‘self-medication’):
Clients report that drugs such as CNS depressants (e.g. alcohol, cannabis, opioids, benzodiazepines) improve their PTSD symptoms
Self-Medication Hypothesis

- Clinical evidence suggests that the choice of substances (CNS depressants vs. stimulants) may stem from the particular constellation of PTSD symptoms that clients experience:

  [e.g. PTSD clients with Alcohol Dependence exhibit significantly more arousal symptoms than do clients with Cocaine Dependence]
Self-Medication Hypothesis
(Cont’d)

Substances may be taken initially to ameliorate PTSD symptoms:

• CNS depressants provide symptom relief
  - however, physiologic arousal resulting from substance withdrawal may have an additive effect with arousal symptoms from PTSD

• The resulting ‘hyper-aroused’ state may serve as conditioned reminder of traumatic events; and thus, precipitate an increase in re-experiencing trauma symptoms
Self-Medication Hypothesis
(Cont’d)

• With exacerbation of PTSD symptoms, client may be prompted to relapse on substances in an attempt to self-medicate

• Thus, for the PTSD client who already suffers symptoms of hyperarousal, the additional arousal related to substance withdrawal, may be intolerable
Self-Medication Hypothesis (Cont’d)

In the ‘self-medication’ model:

• Withdrawal from substances (particularly CNS depressants), may initiate a cycle that perpetuates relapse and continued substance use

• Withdrawal syndromes associated with many CNS depressants overlap extensively with the arousal symptoms of PTSD
### Functional Relationship Examples

<table>
<thead>
<tr>
<th>PTSD SYMPTOM:</th>
<th>Effect of Substance Use:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Intrusive thoughts, images, perceptions</td>
<td><strong>Worsened by:</strong></td>
</tr>
<tr>
<td></td>
<td>• stimulants, alcohol, hallucinogens</td>
</tr>
<tr>
<td>(2) ‘Re-experiencing’ of trauma</td>
<td>• Stimulant-induced hallucinations</td>
</tr>
<tr>
<td></td>
<td>• Dissociative symptoms – may occur during alcohol intoxication</td>
</tr>
<tr>
<td>(3) Intense psychological distress with exposure to cues resembling trauma</td>
<td><strong>Heightened by:</strong></td>
</tr>
<tr>
<td></td>
<td>• stimulants/alcohol</td>
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</tbody>
</table>
Functional Relationship Examples (cont’d)

<table>
<thead>
<tr>
<th>PTSD SYMPTOM:</th>
<th>Effect of Substance Use:</th>
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<tbody>
<tr>
<td>(4) Physiological reactivity on exposure to cues resembling trauma</td>
<td>• Must differentiate between panic attack induced by: cocaine/other stimulant/cannabis/alcohol</td>
</tr>
</tbody>
</table>
| (5) **Avoidance (Numbing):**  
  • Avoidance of thoughts/feelings/people/places associated with trauma | **Self-medication (relief/escape):**  
  • Substance is used to avoid trauma-associated stimuli & distressing internal states |
| (6) Inability to recall aspects of trauma | **Memory impairment due to use of:**  
  • Alcohol, stimulants, benzos, opiates, cannabis |
### Functional Relationship Examples (cont’d)

<table>
<thead>
<tr>
<th>PTSD SYMPTOM:</th>
<th>Effect of Substance Use:</th>
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</thead>
<tbody>
<tr>
<td>(7) Diminished interest/ participation in activities</td>
<td>•May be secondary to substance-induced Dysphoria</td>
</tr>
<tr>
<td>(8) Hyperarousal:</td>
<td>Frequently present due to many types of substance abuse:</td>
</tr>
<tr>
<td>•Sleeping &amp; concentration difficulties</td>
<td>•Stimulants</td>
</tr>
<tr>
<td>•irritability</td>
<td>•Alcohol</td>
</tr>
<tr>
<td>•hyper vigilance</td>
<td>•Or Opiate withdrawal</td>
</tr>
<tr>
<td>•exaggerated startle response</td>
<td></td>
</tr>
<tr>
<td>•psychomotor agitation</td>
<td></td>
</tr>
<tr>
<td>•anxiety</td>
<td></td>
</tr>
<tr>
<td>•autonomic hyperactivity</td>
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</table>
### Comparing Increased Arousal in PTSD/CNS Depressant Withdrawal

<table>
<thead>
<tr>
<th>PTSD Symptoms of Increased Arousal:</th>
<th>Symptoms of CNS Depressant Withdrawal:</th>
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<tbody>
<tr>
<td>• Difficulty sleeping</td>
<td>• Insomnia</td>
</tr>
<tr>
<td>• Irritability/anger</td>
<td>• Psychomotor agitation/ anxiety</td>
</tr>
<tr>
<td>• Difficulty concentrating</td>
<td>• Autonomic hyperactivity</td>
</tr>
<tr>
<td>• Hypervigilance</td>
<td>• Increased hand tremor</td>
</tr>
<tr>
<td>• Exaggerated startle response</td>
<td>• Transient hallucinations</td>
</tr>
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<td></td>
<td>• Seizures</td>
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Vicious Cycle of PTSD/SUD

Figure: Illustration of the hypothetical vicious cycle involved in PTSD-SUD comorbidity maintenance (Sherry H. Stewart and Patricia J. Conrod, 2002)
Treatment of Concurrent Trauma & Substance Use Disorders
Concurrent Treatment...Then

- Historically, first treat the SUD, then PTSD
- Concurrent treatments were first studied in the veteran population
- First, excluded exposure,
- Then modified exposure to in-vivo situations to diminish cues for SUD
Treatment of Concurrent PTSD & SUD…Now

Recent best practice recommendations suggest that treatment techniques should combine standard substance disorder/trauma-related treatment
Treatment of Concurrent SUDs & PTSD

• Overall task of therapist: motivate clients towards healthy choices rather than short-sighted, self-destructive, pleasure-seeking behaviours

• Must educate clients about origins of their lack of self-care and self-destructive behaviours

• Assist clients to reduce/cease substance use while recognizing/addressing emotional vulnerabilities and teach new practical ways to cope
Treatment of Concurrent SUDs & PTSD

- Historically: first treat SUD and then PTSD

- Concurrent treatments first studied in the veteran population

- First excluded exposure, then modified exposure to in vivo situations to diminish cues for SUD
Treatment of
Concurrent SUDs & PTSD

• Dealing with past trauma in substance abusing clients traditionally seen as contraindicated (exploration of past trauma would be emotionally overwhelming and would lead to substance use exacerbation)

• Addiction therapists ignored the trauma and focused solely on drug/alcohol use
Treatment of Concurrent SUDs & PTSD

- Attempting to treat traumatized substance using clients with traditional approaches focusing first on substance use and later on psychiatric comorbidity usually unsuccessful

- High levels of psychic distress/interpersonal conflict: may be impossible to reduce substance use/maintain abstinence
Treatment of Concurrent SUDs & PTSD

• Due to complex interplay of symptoms in SUD clients with trauma histories, it is difficult to determine which symptoms are substance-induced and which are related to unprocessed trauma.

• Must take comprehensive, holistic approach by addressing SUD and PTSD concurrently.
### Parallels in Traditional Treatment Approaches

<table>
<thead>
<tr>
<th>For SUDs:</th>
<th>For PTSD:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staged model of change:</strong></td>
<td><strong>Stepped-Care:</strong></td>
</tr>
<tr>
<td>• Engagement</td>
<td>• Early engagement</td>
</tr>
<tr>
<td>• Persuasion</td>
<td>• Self-care/resist self-destruction (symptom stabilization)</td>
</tr>
<tr>
<td>• Stabilization</td>
<td>• Maintain improvements</td>
</tr>
<tr>
<td>• Maintenance</td>
<td></td>
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</tbody>
</table>
Parallels in Traditional Treatment Approaches (cont’d)

<table>
<thead>
<tr>
<th>SUDs:</th>
<th>PTSD:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• clients taught skills to deal with triggers to substance use/how to make changes in lifestyle (coping with exposure to substances in everyday life - emergency plans to avoid/ interrupt relapses)</td>
<td>• Also involves early, middle &amp; late stages of treatment with exposure to everyday life and multiple reminders of trauma</td>
</tr>
<tr>
<td></td>
<td>• Use skills to cope with these stressors that could lead to emotional decompensation</td>
</tr>
</tbody>
</table>
Parallels in Traditional Treatment Approaches (cont’d)

Striking similarities in the tx techniques of both disorders:
• Staging
• Taking a long-term perspective
• Stabilization before attempting insight
• Building basic relational skills before dealing with symptoms
• Treatment for both includes: empathy, support, and psycho-education
Parallels In Traditional Treatment Approaches

• Treatment for both disorders focuses first on symptom reduction/resolution and actively teaching coping skills

• Both work on self-esteem to reduce self-destructive tendencies

• Empathy is key in combating shame

• Therapist is supportive & directive: Uses simple communication to overcome potential neurological/educational deficits
Best Practice Recommendations for PTSD & SUD

• For PTSD, do not sequence interventions

• Instead, use an ‘integrated approach’ that deals with substance use and mental health at the same time

• CBT approach
Stages of Trauma

Overview
<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysteria (Janet, 1989)</td>
<td>• Stabilization</td>
<td>Exploration of traumatic memories</td>
<td>• Personality-Integration</td>
</tr>
<tr>
<td></td>
<td>• Symptom-oriented treatment</td>
<td></td>
<td>• Rehabilitation</td>
</tr>
<tr>
<td>Complicated PTSD (Brown and Fromm)</td>
<td>• Stabilization</td>
<td>Integration of memories</td>
<td>• Development of self</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Drive integration</td>
</tr>
<tr>
<td>Multiple Personality Disorder (Putnam 1989)</td>
<td>• Diagnosis</td>
<td>Metabolism of trauma</td>
<td>• Resolution</td>
</tr>
<tr>
<td></td>
<td>• Stabilization</td>
<td></td>
<td>• Integration</td>
</tr>
<tr>
<td></td>
<td>• Communication</td>
<td></td>
<td>• Development of post-resolution skills</td>
</tr>
<tr>
<td></td>
<td>• Cooperation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic Disorders (Hermann 1992)</td>
<td>• Safety</td>
<td>Remembrance and Mourning</td>
<td>Reconnection</td>
</tr>
</tbody>
</table>
‘1\textsuperscript{st} Stage’ Trauma Treatment

1\textsuperscript{st} stage includes:

- stabilization
- reflection
- and grounding.

- It DOES NOT involve exposure therapy. Most clinicians do not make distinctions between 1\textsuperscript{st} Stage and 2\textsuperscript{nd} Stage.
- Most clients must complete 1\textsuperscript{st} Stage treatment before moving on to 2\textsuperscript{nd} Stage.
‘Stage 2’ Trauma Treatment

- 2nd stage (or exposure work) focuses on the event, the narratives connected to the event.
- If a clinician begins 2nd Stage treatment before 1st Stage is completed, they risk re-traumatizing the client.

Stage 2 examples:
- Telling story/breaking silence/validation
- Prolonged Exposure
- Flooding
- Systematic desensitization
- EMDR (Eye Movement Desensitization and Reprocessing) (Shapiro, 1995) is an evidenced-based Stage 2 treatment for PTSD; but evidence for effectiveness in a CD population is still under research
Stage II CDS Trauma Group

- Based on Judith Hermann’s model
- Psychodynamic in orientation
- Pam to add more…
Stage II Targets

- Intrusive symptoms
- Avoidance of emotions, situations and experiences
- Emotion dysregulation (heightened emotional experiencing and inhibited emotional experiencing, specifically related to anxiety/fear, anger, sadness, shame/guilt)
- Self-invalidation
- Prioritization of targets based on level of severity and life disruption, clients’ goals and the functional relationship between targets
- Exposure becomes a primary intervention in Stage II DBT (formal and informal)

[Chapter in: V.M. Follette & J. Ruzek (Eds), Cognitive Behavioral Therapies for Trauma]
‘Stage 3’ Trauma Treatment

INCREASED PERSONAL GROWTH via:

• learning to fight
• reconciling with oneself
• reconnecting with others
• finding a survivor mission
• resolving the trauma
Treatment Approaches/Models: for Concurrent Substance Use & PTSD

(1) Triffleman’s Model (Trifflemans et al., 2000)

(2) Seeking Safety (Najavits, Weiss, Shaw and Muenz, 1998)
Triffleman’s Model (2 Phases)

**Phase I:**
- Lasts 12 weeks, trauma-informed, addictions–focused tx
- Includes: coping with cravings, drug use triggers, relaxation training, HIV risk behaviors, anger, awareness and coping skills

**Phase II:**
- The client has the necessary skills to tolerate the increased negative affect associated with trauma-focused therapy, without relapsing to substance use
- Focuses on anti-avoidance; using SIT, cognitive restructuring and in-vivo exposure (short exposures)
Triffleman’s Model (Cont’d)

Phase II (Cont’d):

Clients who did not respond were individuals with:

- Extremely poor memories of their trauma
- Poor visual image ability
- Inability to tolerate or modulate distress caused by exposure
- Experienced marked dissociation during exposure and were unable to use grounding techniques
• Offers a manualized EBP (evidence based practice) approach to 1st stage treatment for trauma and substance use
• It’s a non-exposure model
• It’s a ‘present-focused’ therapy to help clients attain safety from both PTSD and substance abuse
• It consists of 25 topics divided among: cognitive, behavioural and interpersonal domains
• Each addresses a “safe coping skill” designed to help patient attain safety from both PTSD and substance abuse.
About Seeking Safety (SS)

Topics are:
• in simple language,
• emotionally compelling

Provides:
• a respectful tone that honors client’s courage in fighting the disorders
• and teaches new ways of coping that convey the idea that no matter what happens, they can learn to cope in safe ways without substances and other destructive behaviour.
SS ‘Interpersonal’ Topics

1. Honesty
2. Asking for Help
3. Setting Boundaries in Relationships
4. Getting Others to Support your Recovery
5. Healthy Relationships
6. Community Resources
SS ‘Cognitive’ Topics

1. PTSD: Taking Back your Power
2. When Substances Control You
3. Discovery
4. Recovery Thinking
5. Creating Meaning
6. Integrating the Split Self
7. Compassion
SS ‘Behavioral’ Topics

1. Taking Good Care of Yourself
2. Commitment
3. Respecting Your Time
4. Coping with Triggers
5. Self Nurturing
6. Red and Green Flags
7. Detaching from Emotional Pain (Grounding)
About Seeking Safety (Cont’d)

Other Topics:
1. Introduction/Case Management
2. Safety
3. Life Choices
4. Termination

Designed for flexible Use:
• Group/Individual formats
• Women/Men/Mixed Gender
• Can use all/fewer topics
• Applicable to a variety of settings and providers
Key Principles of Seeking Safety

- **Safety as priority** for first stage treatment
  
  Safety from:
  - Substances
  - Dangerous relationships
  - Extreme symptoms - dissociation and self-harm

- **Integrated treatment** for both disorders at the same time
Key Principles of Seeking Safety (Cont’d)

- **A focus on ideals** to counteract the loss of ideals in both PTSD and substance abuse

- **Four content areas** cognitive, behavioural, interpersonal and case management

- **Attention to therapist processes** balance praise with accountability, notice counter-transference, self care
SS Additional Features

- Trauma details are not part of group therapy
- Identify meanings of substance use in the context of PTSD
- Optimistic - future and strength focus
- Help patients obtain more treatment and attend to daily life problems
SS Outcome Studies x7: All positive
(for the full articles, go to: www.seekingsafety.org)

(1) 17 women outpatients using group treatment (Najavits et al., 1998)

(2) 17 women in prison using group treatment (Zlotnick et al., 2003)

(3) Controlled randomized study of 83 women either in ‘Seeking Safety’ vs. ‘Relapse Prevention’ compared to ‘Treatment-as-Usual’ in the community, using individual treatment (Hien et al., 2004)

(4) Controlled randomized study of adolescent outpatient girls (Najavits et al., 2006)

(5) Pilot: 5 male outpatients combining ‘Seeking Safety plus Exposure’, using individual treatment (Najavits et al., 2005)

(6) Women in a community mental health program (Holdcraft et al., 2002)

(7) Men and Women veterans (Cook et al., 2006)
## Professional Issues (Najavits)

<table>
<thead>
<tr>
<th>PTSD:</th>
<th>Tends to evoke identification with client’s vulnerability; excessive support at the expense of growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD:</td>
<td>Anxiety about client’s substance use; which, if extreme, can become harsh, judgment and control</td>
</tr>
<tr>
<td>Integrate:</td>
<td>Support and accountability are the 2 central processes in the treatment</td>
</tr>
</tbody>
</table>
Countertransference in the treatment of PTSD and SUDs

• Client attempts to avoid unbearable affect

• Relationship with therapist termed ‘a difficult treatment dyad’

• Therapist may become torn between sadistic abandonment and collusive indulgence, with concomitant desires to rescue and desert clients
Countertransference in the treatment of PTSD and SUDs

• The therapeutic alliance is the cornerstone of successful treatment with concurrent disorders clients

• With PTSD/SUD clients in particular, successful treatment depends on management of therapist countertransference and phenomenon of parallel process
Conclusions

• It is the continued active PTSD that appears to be a critical factor in the relationship between PTSD and substance abuse outcomes.

• Treatment providers should be warned against viewing PTSD as secondary to SUDS and assuming that successfully treating the alcohol/drug problem alone will somehow result in improving PTSD symptoms.
Conclusions

- Persons with a PTSD diagnosis may present to treatment with poorer coping skills (no gender differences were found at either at baseline or at follow-up coping).

- Although women are at increased risk for exposure to trauma, and to subsequent development of PTSD, female gender is not necessarily a risk factor for poorer long-term PTSD outcomes.
Incorporating Trauma-Informed Practice in your settings

1. Level 1 CD Capability training is ongoing

Ongoing CD Capacity-Building:

1. Cross Training observation of Seeking Safety Groups
2. Referral to Specialized (Level 2) CDS, when required
3. Inter-Service Collaboration for Integrated Tx
4. Access to consultation
5. Mechanisms for supervision
6. Trauma & Addiction Community of Practice
References
(Stage 1 Trauma & Substance Use)


References (cont’d)
(Stage 1 Trauma & Substance Use)


Questions?
Comments?
Feedback?
Thank You for Attending!

- CAMH contacts in Waterloo Wellington
  - Kim Baker, Program Consultant
    kim_baker@camh.net
  - Pat Allan, Program Consultant
    pat_allan@camh.net