Truama, Substance Use, and Trauma-Informed Care

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What we'll cover

- Review definitions of trauma
- Develop understanding of the relation between trauma and substance use
- Identify opportunities to enhance client engagement using a trauma-informed approach

Addiction is, Fundamentally,
A *Brain Disease*

…BUT

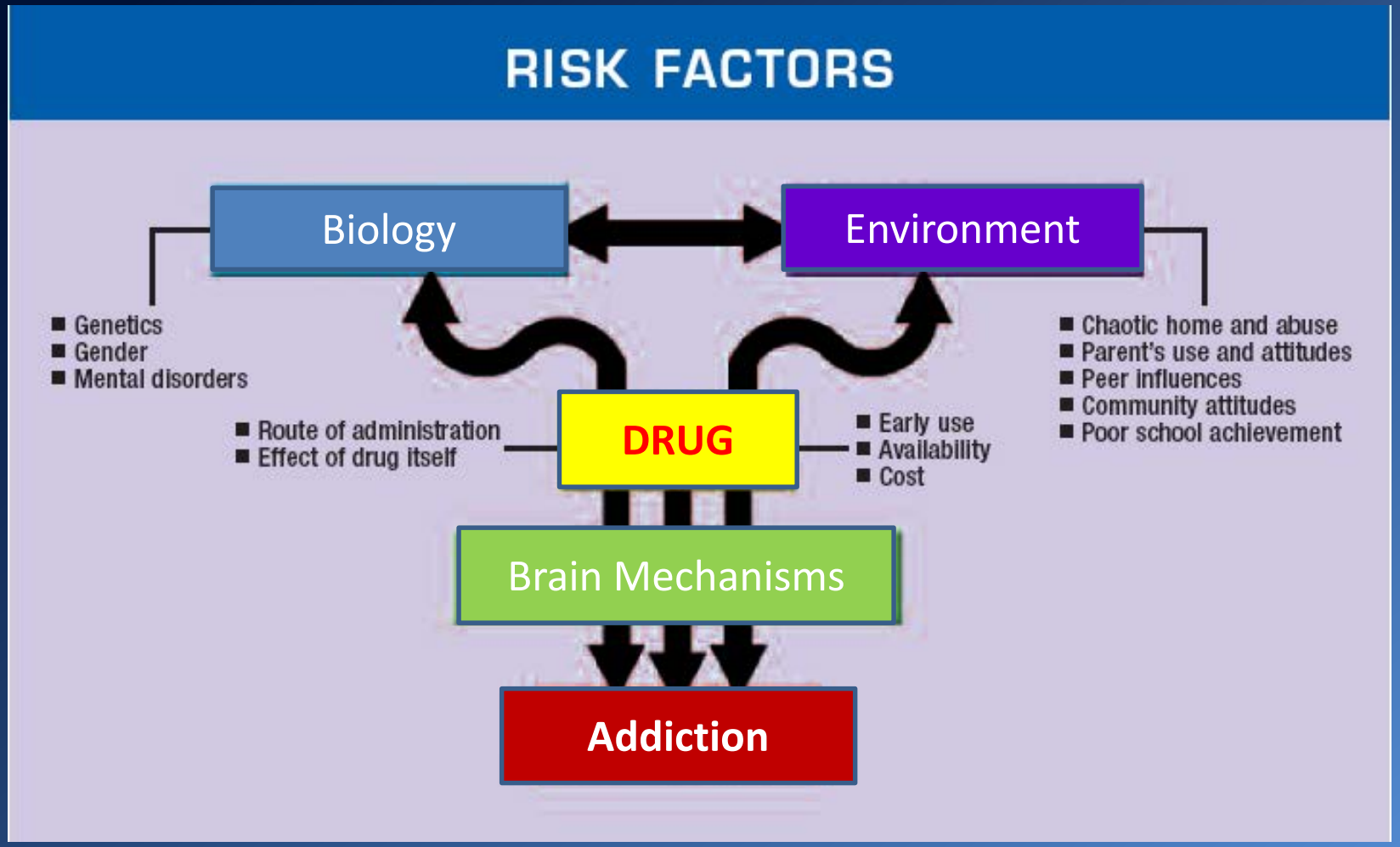
It's Not *Just* a Brain Disease

Vulnerability to addiction differs from person to person

Between 40 and 60 percent of a person's vulnerability to alcohol and tobacco addiction is due to **genetic influences**

Vulnerability to addiction differs from person to person

Environmental factors (e.g., conditions at home, at school, and in the neighbourhood) also play a role


RISK FACTORS
Biology
Environment
Genetics
Gender
Mental disorders
Chaotic home and abuse
Parent's use and attitudes
Peer influences
Community attitudes
Poor school achievement
Route of administration
Effect of drug itself
DRUG
Early use
Availability
Cost
Brain Mechanisms
Addiction

What is Trauma?

DSM Criteria

- DSM-5 Criteria:
  - Exposure to actual or threatened death, serious injury, or sexual violence
    - For adults, includes repeated exposure to details
    - For children, includes events occurring to caregiver
  - Four clusters of symptoms
    - Intrusive symptoms
    - Avoidance
    - Negative alterations to mood or cognition
    - Changes in arousal/reactivity
  - Additional considerations (duration, impairment)

Who experiences trauma?

- 61% of men and 51% of women report experiencing or witnessing a trauma in their lifetime
- Natural disaster or experiencing life-threatening accident ranked highest

(Kessler et al, 1999)

- Second study found:
  - 71.6% reported witnessing trauma
  - 30.7% experienced a trauma resulting in injury
  - 17.3% reported psychological trauma

(El-Gabalawy, 2012)

Trauma in Justice-Involved Populations

- Most estimates identify trauma as a nearly universal experience among people:
  - In public mental health
  - In substance abuse treatment
  - Involved with social services
  - Justice-involved
  - Homeless
- Justice-involved women are more likely than justice-involved men or the general public to have experienced sexual or physical abuse

Trauma in Justice-Involved Populations

- Research on trauma prevalence among offender populations is difficult to narrow down
- Studies show prevalence between 62% and 90%
- Women are statistically safer from victimization in prison than prior (men are not)
- Sexual assault prevalence estimated at 4.4%

Trauma in Justice-Involved Populations

- History of sexual abuse is a risk factor for crime in males and females
- People who have been sexually abused are more likely to be arrested and experience future traumas
- Most commonly reported trauma:
  - Among females: sexual abuse
  - Among males: witnessing someone being killed or seriously injured

Trauma in Justice-Involved Populations

- Higher rates of trauma and earlier onset of trauma associated with increased violence and victimization in prison
- Underreporting trauma may be common due to lack of trust or normalization of experiences
- Vicarious trauma or direct exposure to traumatic events (leading to PTSD or burnout) is not uncommon among corrections staff

Review of Trauma

- 3 types of stressors
  - Positive → helping to guide growth
  - Tolerable → not helpful, but not causing lasting harm
  - Toxic → sufficient to overcome one's coping mechanisms and lead to long-term impairment

Review of Trauma

BIG T

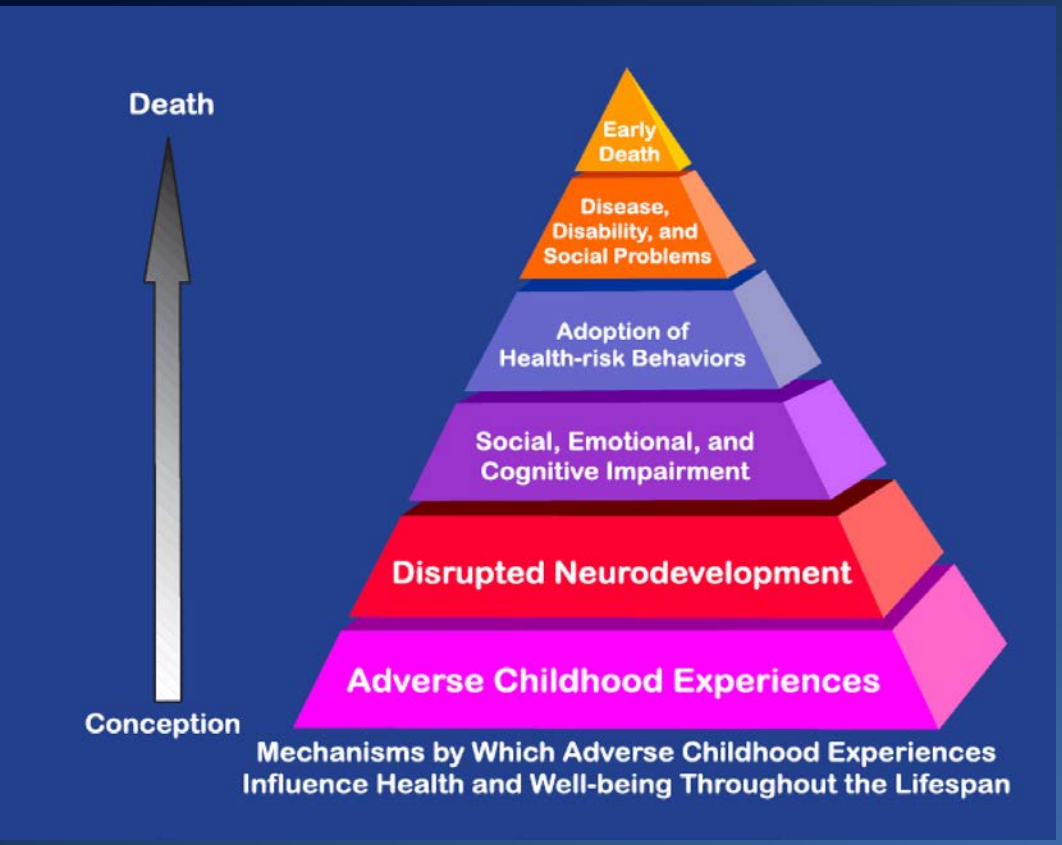
- War
- Disasters
- Childhood sexual abuse
- Physical abuse
- Car wreck
- Crime victimization
- Witnessing death
- Domestic violence

little t

- Emotional abuse
- Neglect
- Failure experiences
- Phobia related experiences
- Losses
- Stress at work or school
- Bullying
- Domestic violence

The ACE Study

Adverse Childhood Experiences Study (ACE)



- Ongoing collaborative research between the CDC and Kaiser Permanente
- Over 17,000 Kaiser patients participating in routine health screening volunteered to participate in the study
- Data reveal staggering proof of the health, social, and economic risks that result from childhood trauma

SOURCE: The ACE Study, http://acestudy.org.

The ACE Questionnaire

- Verbal or emotional intimidation/abuse
- Physical abuse/hitting
- Sexual abuse
- Emotional neglect/feeling unloved or supported
- General neglect, basic needs not met
- Parents ever separated or divorced
- Witnessed domestic violence or abuse against a caregiver
- Household drinker or drug user
- Depressed or mentally ill household member
- Incarcerated family member

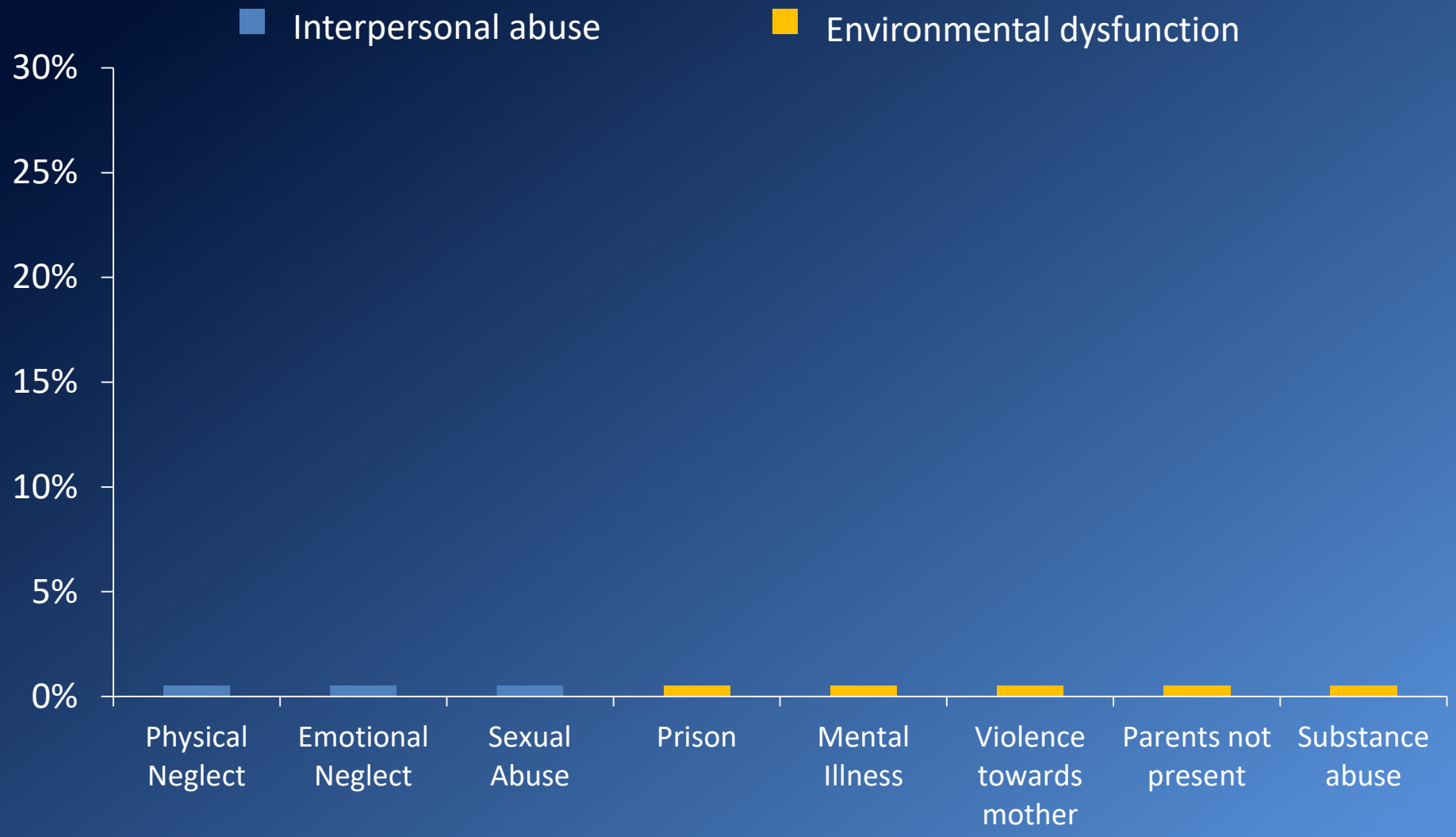
SOURCE: The ACE Study, http://acestudy.org.

Major Findings of the ACE Study

- ACEs such as childhood abuse, neglect, and exposure to other traumatic stressors are common
- Almost two-thirds of the ACE Study participants reported at least one ACE, and more than one of five reported three or more ACE
- The short- and long-term outcomes of these childhood exposures include a multitude of health and social problems

SOURCE: The ACE Study, http://acestudy.org.

Results of the ACE Study



SOURCE: The ACE Study, http://acestudy.org.

The ACE Study

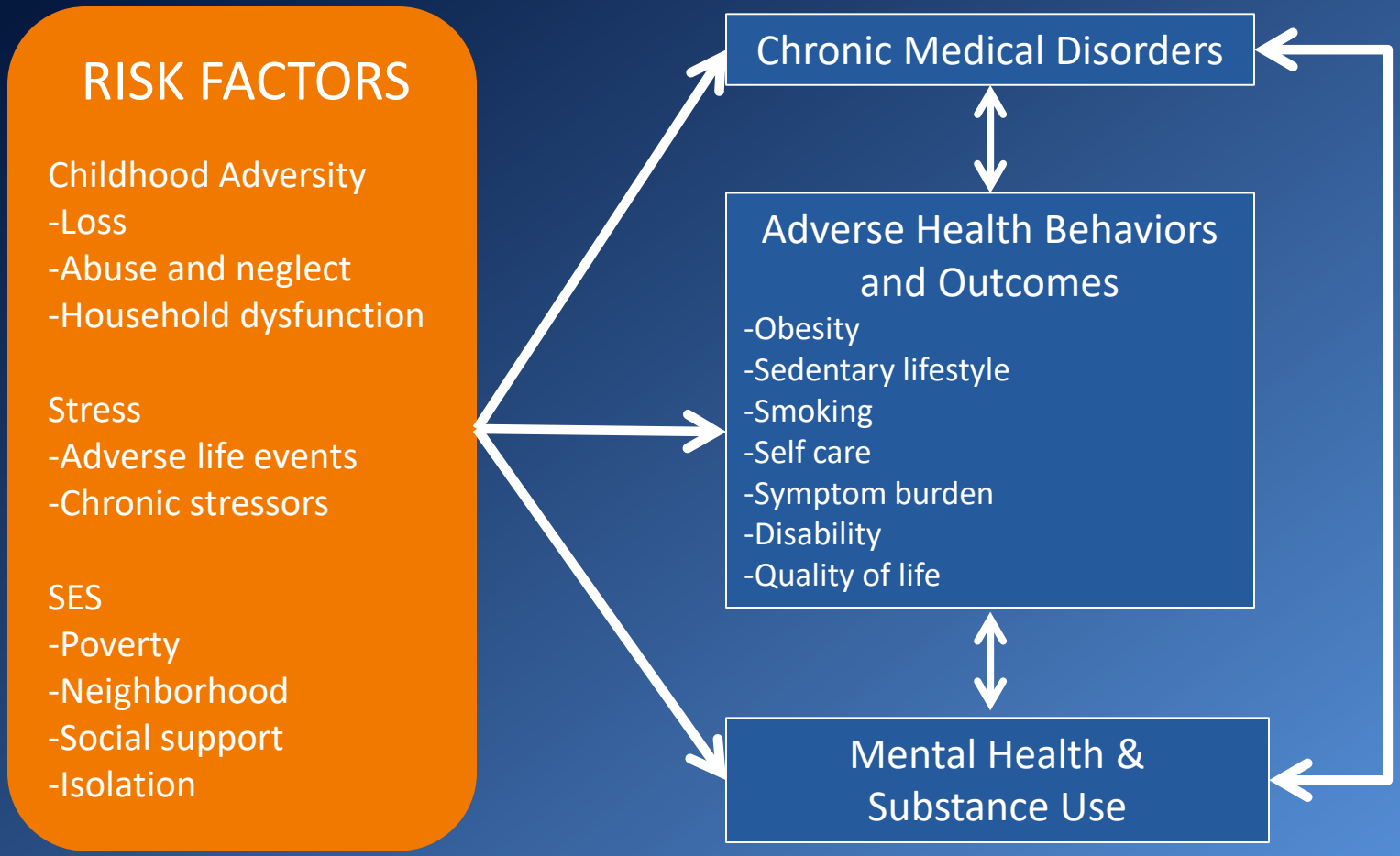
What Happens Later in Life?

The ACE Score – Risk for Health Problems

- **Alcoholism and alcohol abuse**
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- **Illicit drug use**
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- **Smoking**
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy

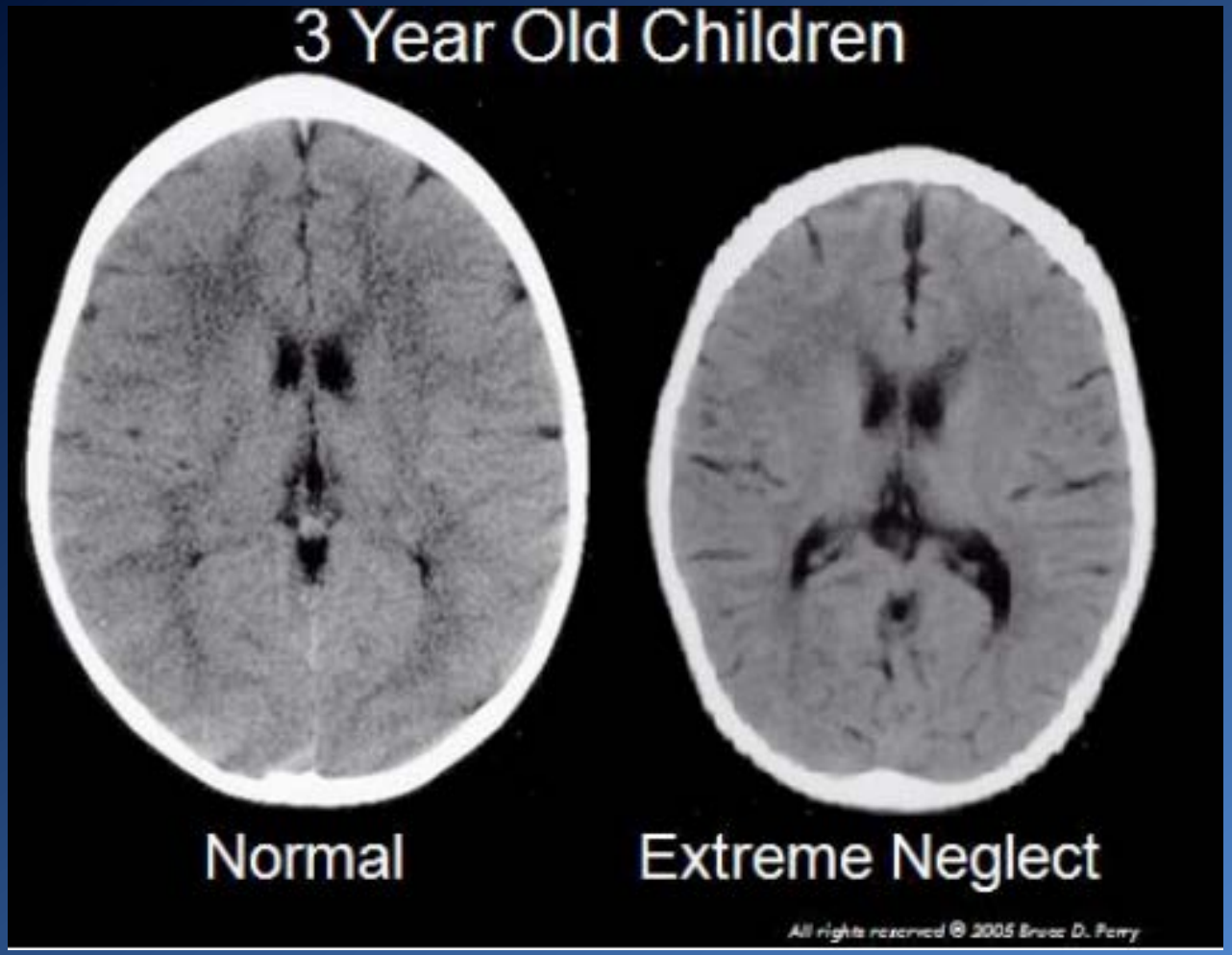
SOURCE: The ACE Study, http://acestudy.org.

Mental Health, Substance Use, and Physical Health are Interconnected



Druss, B.G., and Walker, E.R. (February 2011).

Trauma and the Brain



Child Maltreatment: A Neurodevelopmental Perspective on the Role of Trauma and Neglect in Psychopathology Bruce D. Perry, M.D., Ph.D John Wiley & Sons, Hoboken, NJ 2008 pp. 93

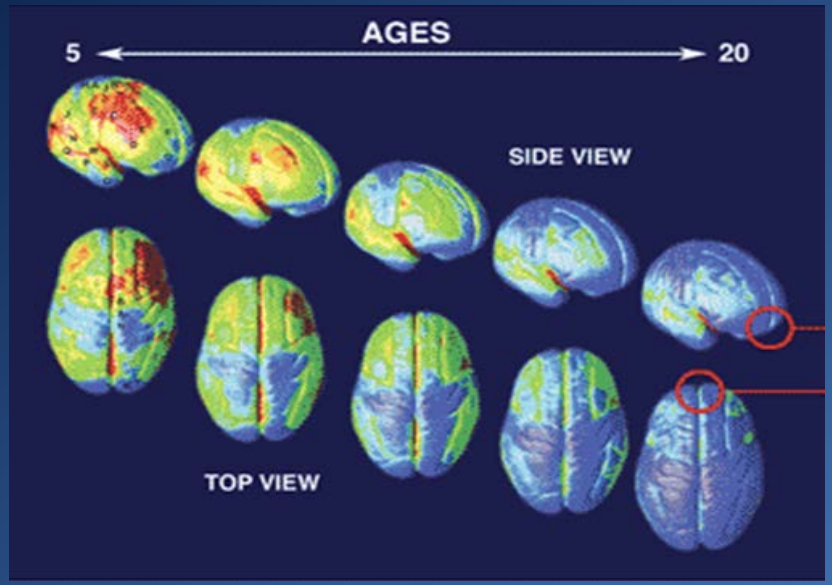
Continuing Brain Development

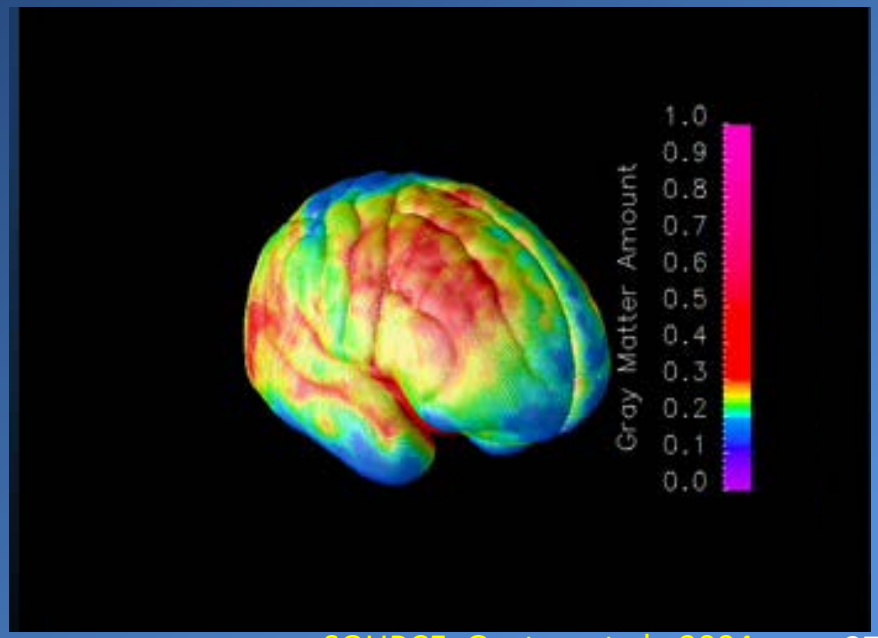
Early in development, synapses are rapidly created and then pruned back. Children's brains have twice as many synapses as the brains of adults.

SOURCE: Shore, 1997.

Brain Development
Ages 5-20 years

- MRI scans of healthy children and teens compressing 15 years of brain development (ages 5–20).
- Red indicates more gray matter, blue less gray matter.
- Neural connections are pruned back-to-front.
- The prefrontal cortex ("executive" functions), is last to mature.

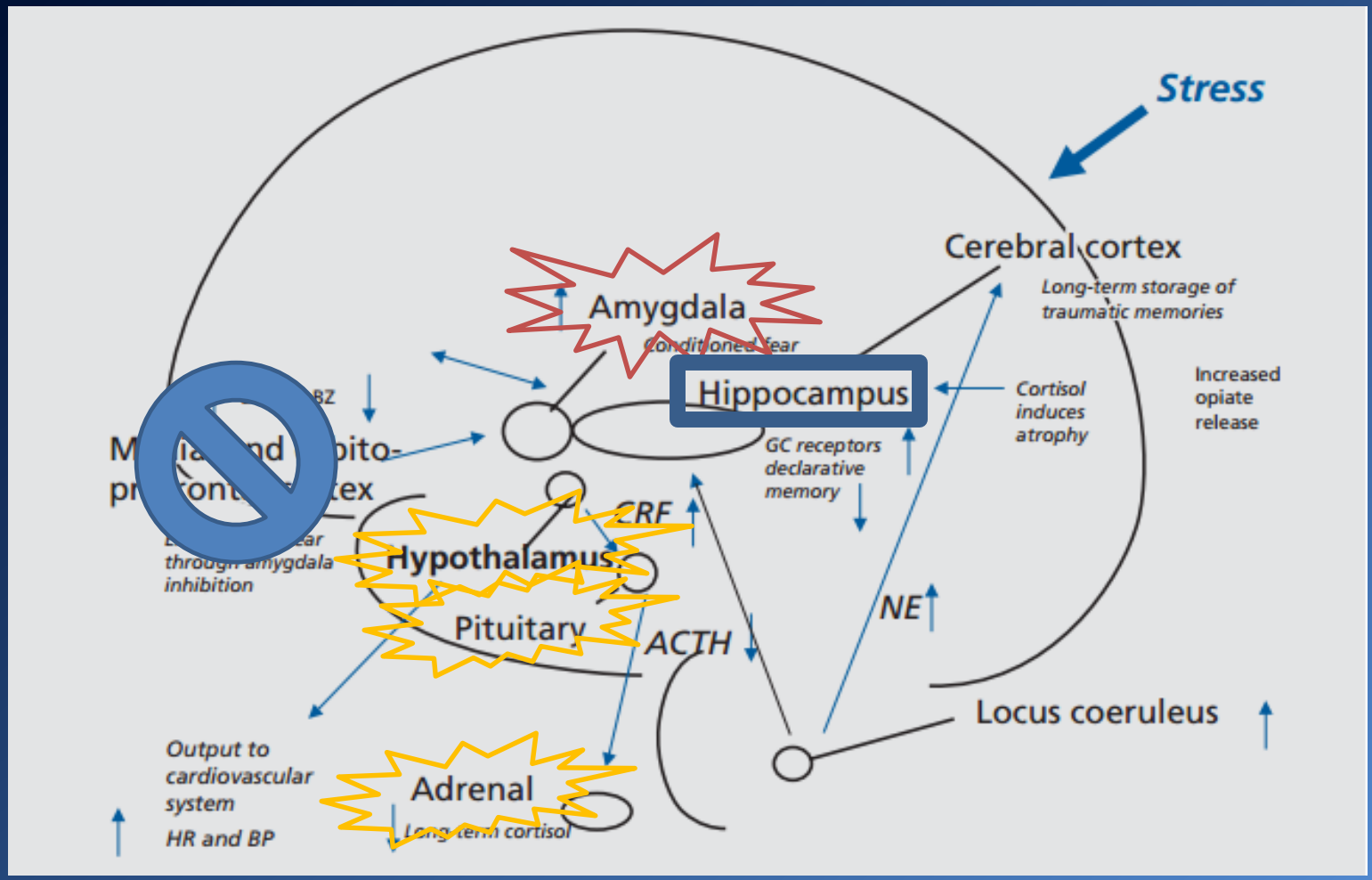




Information taken from NIDA's *Science of Addiction*
http://www.drugabuse.gov/ScienceofAddiction/

SOURCE: Gagtay, et al., 2004.

Trauma and the Brain



SOURCE: Bremner, 2006

Trauma and the Brain

- Affects hippocampus and amygdala development
- Traumatized individuals “bypass” the prefrontal cortex when triggered
- During development, impaired growth in left hemisphere contributes to depression
- Impaired connection between hemispheres

SOURCE: BA van der Kolk, 2003

ACEs and Violence

- Minnesota Student Survey found that adolescent males were 35%-144% more likely to engage in violence for each ACE endorsed
- Males were 45x more likely to engage in intimate partner violence when reporting childhood sexual abuse
- Individuals in corrections are 4x as likely to have experienced 4+ ACEs

ACEs and Criminal Justice

- A criminal psychologist administered the ACEs study to over 100 convicted killers
- The average score reported to him was 8
- Only 1 in 1000 Americans has an ACE score of 8 or higher

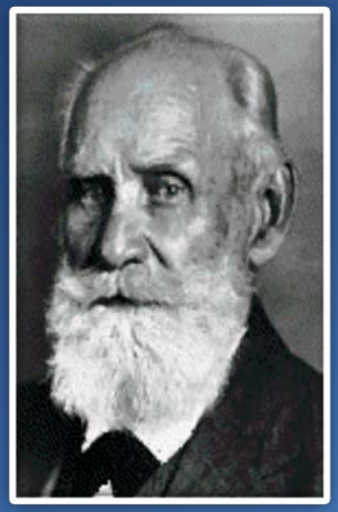
- A study of 152 adolescent offenders found that over 90% indicated having experienced at least one traumatic event
- 33.6% indicated having experienced 8 or more

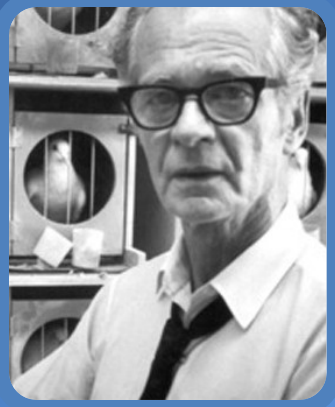
Trauma-Informed Care in Corrections

A Trauma-Informed Approach

Conceptualizing Behavior

- Social learning theory
- Classical conditioning
- Operant conditioning
  - Positive Reinforcement
  - Negative Reinforcement
  - Punishment

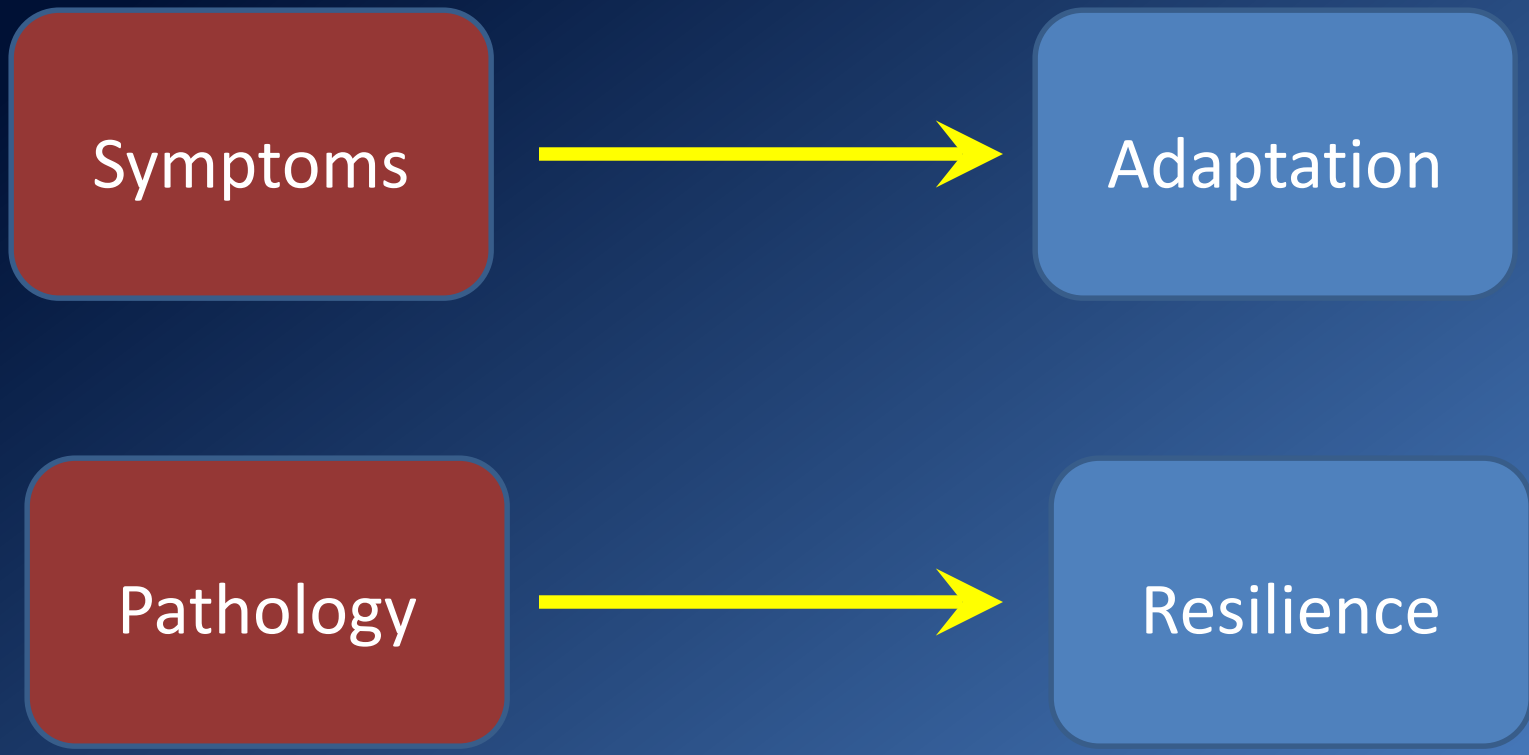




NIDA Clinical Trials Study

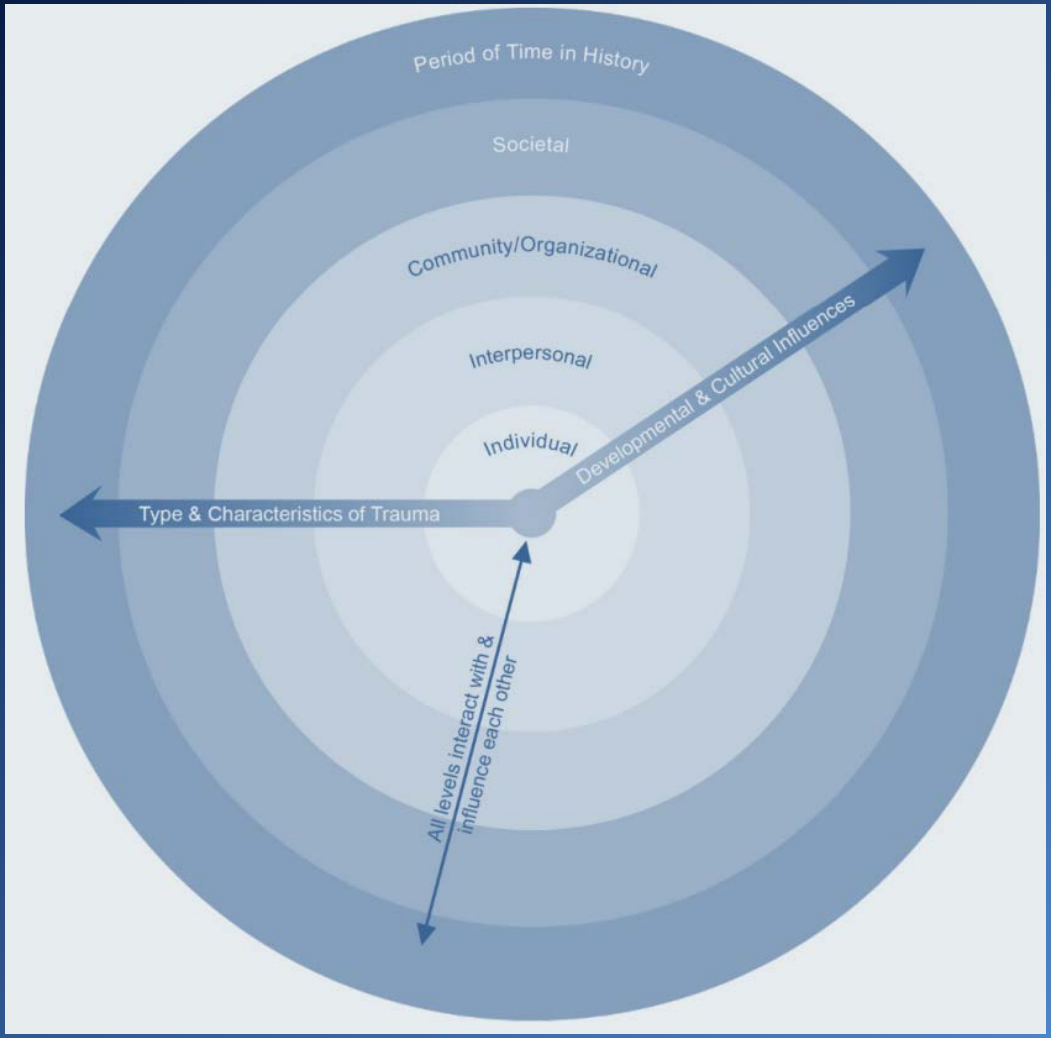
- Purpose was to improve PTSD and SUD symptoms among women in an outpatient setting
- One group received trauma-focused interventions
- Reductions in PTSD were more likely to be associated with substance use improvement
- The opposite was not true

SOURCE: Hien, et al. (2010)



Moving from "what's wrong with you" to "what happened to you."

A socio-ecological conceptualization of trauma



What is Trauma-Informed Care?

Trauma-Informed

- Recognition of high prevalence of trauma
- Recognition of primary and co-occurring trauma diagnoses
- Recognition of culture and practices that are re-traumatizing

Non Trauma-Informed

- Lack of education on trauma prevalence and universal precautions
- Over-diagnosis of schizophrenia, bipolar d/o, conduct d/o, singular addictions
- Cursory or no trauma assessment
- “Tradition of Toughness” as best care approach

What is Trauma-Informed Care?

Trauma-Informed

- Power/control minimized – constant attention to culture
- Caregivers/supporters - collaboration
- Address training needs of staff to improve knowledge & sensitivity

Non Trauma-Informed

- Staff demeanor, tone of voice
- Rule enforcers – compliance is key
- “Patient blaming” as fallback position without training

What is Trauma-Informed Care?

Trauma-Informed

- Staff understand function of behavior
- Objective, neutral language
- Transparent systems open to outside parties

Non Trauma-Informed

- Behavior seen as intentionally provocative
- Labeling language: “manipulative,” “needy,” “attention-seeking”
- Closed system – advocacy discouraged

Trauma-Informed Organizations

- Safe, calm and secure environment with supportive care
- System wide understanding of trauma prevalence, impact and trauma informed care
- Cultural Competence
- Consumer voice, choice and self-advocacy
- Recovery, consumer-driven and trauma specific services
- Healing, hopeful, honest and trusting relationships

How does your organization measure up?

SOURCE: National Council for Community Behavioral Healthcare, Organizational Self Assessment, 2011

Organizational Adoption of TIC

1. Early screening and assessment of trauma
2. Consumer driven care and services
3. Trauma-informed, educated and responsive workforce
4. Provision of trauma-informed, evidence-based, and emerging practices
5. Create safe and secure environments
6. Engage in community outreach and partnership building
7. Ongoing performance improvement and evaluation

SOURCE: National Council for Behavioral Health, 2011

Goals in Trauma-Informed Care

- Recognize that trauma-related symptoms and behaviors originate from adapting to traumatic experiences
- View trauma in the context of the individual's environments
- Minimize the risk of retraumatizing, replicating prior trauma dynamics
- Create a safe environment
- Identify trauma as a primary goal

SOURCE: SAMHSA, 2014

Develop a Trauma-Informed Plan

- Discuss their initial recall or first suspicion that they were having a traumatic response.
- Become educated on trauma responses.
- Draw a connection between the trauma and presenting trauma-related symptoms.
- Explore their support systems and fortify them as needed.
- Understand that triggers can precede traumatic stress reactions, including delayed responses to trauma.
- Identify their triggers.
- Develop coping strategies to navigate and manage symptoms.

SOURCE: SAMHSA, 2014

The Impact of Trauma

Trauma is like a rock hitting the water's surface

Emotional reactions

- What it looks like
  - Numbness or detachment
  - Anxiety or fear
  - Guilt
  - Anger
  - Helplessness
  - Sadness/shame
  - Depersonalization
  - Lack of control
  - Irritability or depression
  - “Stockholm syndrome”

SOURCE: SAMHSA, 2014

Physical reactions

- What it looks like
  - Nausea
  - Sweating
  - Faintness
  - Skin rash
  - Fatigue or exhaustion
  - Aches and pains
  - Hyperarousal
  - Greater startle response
  - Appetite changes
  - Nightmares/difficulty sleeping

SOURCE: SAMHSA, 2014

Cognitive reactions

- What it looks like
  - Difficulty concentrating
  - Rumination/preoccupation or racing thoughts
  - Self-blame
  - Difficulty making decisions
  - Generalization of triggers
  - Memory problems
  - Intrusive thoughts/flashbacks
  - Distortion of time and space (immediate reaction)
  - Belief that feelings/memories are dangerous
  - Hallucinations and delusions

SOURCE: SAMHSA, 2014

Behavioral reactions

- What it looks like
  - "Jumpy" or easily startled
  - Restlessness
  - Argumentative behavior
  - Difficulty expressing oneself
  - Self-harm, adoption of risky/self-destructive behaviors
  - Withdrawing
  - Fixed or "glazed" eyes
  - Sudden flattening of affect
  - Stereotyped movements
  - Responses not congruent with the present context or situation
  - Excessive intellectualization

SOURCE: Briere, 1996a

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- Belief that feelings/memories are dangerous
- Hallucinations and delusions
- Self-blame

Behavioral Coping

- Interventions
  - Focused breathing
  - Mindfulness/meditation
  - Progressive muscle relaxation
  - Establishing a safe environment
  - Listening to music
  - Grounding techniques

SOURCE: SAMHSA, 2014

Grounding techniques

- Ask the client to state what he/she observes
  - "You're in a safe situation. Let's try to stay in the present. Take a slow deep breath, relax your shoulders, put your feet on the floor; let's talk about what day and time it is, notice what's on the wall, etc. What else can you do to feel okay in your body right now?"
- Help the client decrease the intensity of affect
  - Imagine turning down an "emotional dial", progressive muscle relaxation
- Distract the client from unbearable emotional states
  - Counting tasks, focusing on objects in the room, self-talk to remind of current safety, focus on recent or future events ("to-do" list for the day)
- Ask the client to use breathing techniques

SOURCE: SAMHSA, 2014

Affective Coping

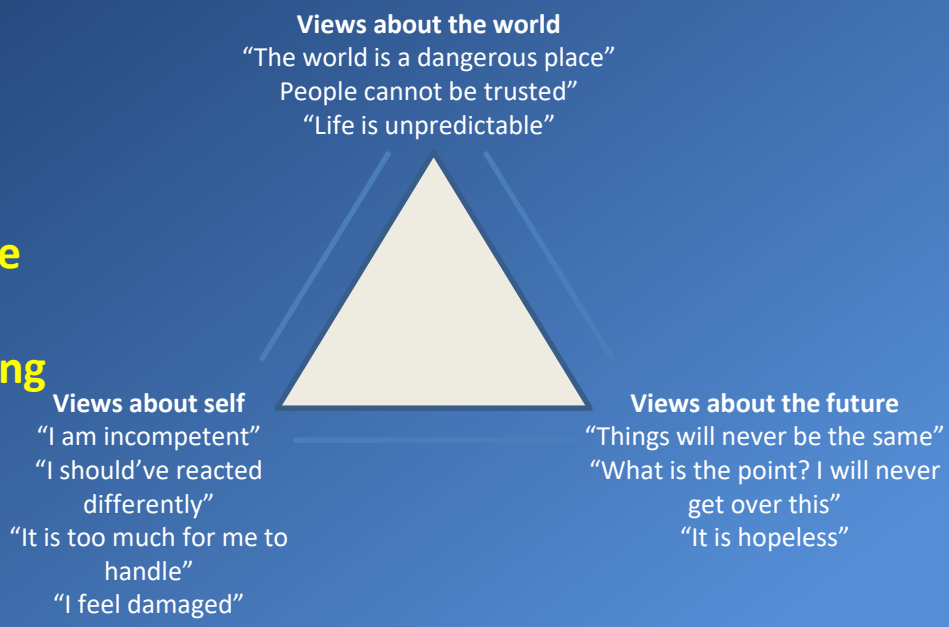
- Interventions
  - Feeling identification
  - Role playing expression of feelings with others
  - Thought interruption
  - Positive imagery
  - Positive self-talk
  - Problem solving
  - Recognition of triggers

SOURCE: SAMHSA, 2014

Cognitive Coping

- Interventions
  - The Cognitive Triangle and anticipating outcomes
  - Enhance personal safety
  - Challenging negative cognitions

•"I can only be happy if I'm involved with someone."
•"Being strong means I should never feel upset."
•"Some problems have to be avoided because they are just too hard to handle."
•"I can't handle how horribly wrong everything is going in life."



SOURCE: SAMHSA, 2014

Cognitive Coping

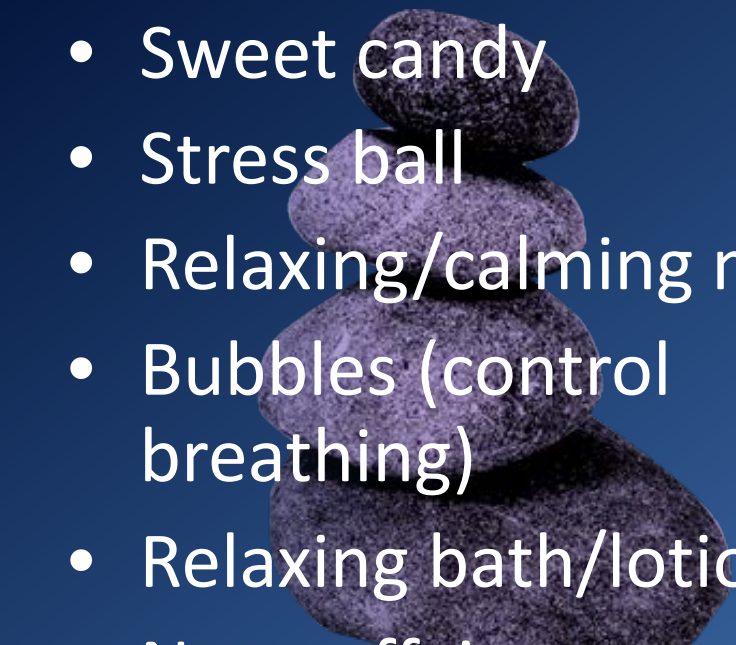
- Interventions
  - The Cognitive Triangle and anticipating outcomes
  - Enhance personal safety
  - Challenging negative cognitions

Exposure therapy

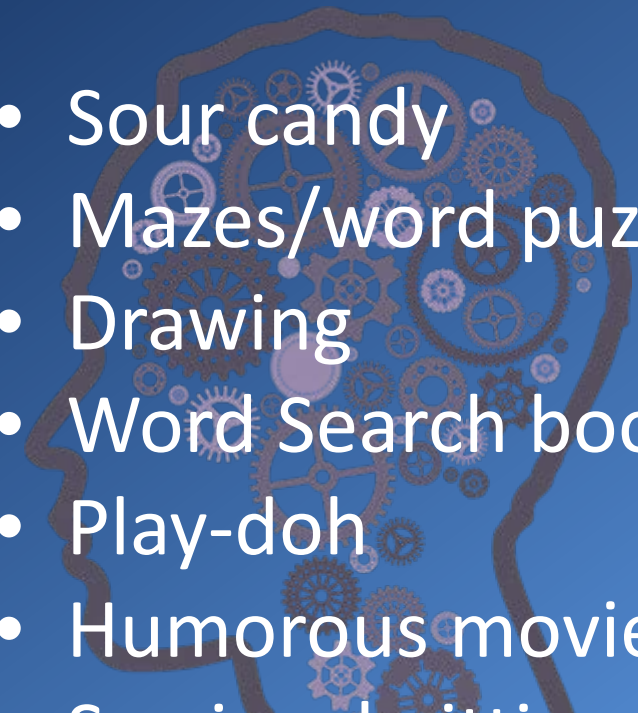
- Interventions
  - Constructing a trauma narrative
  - Builds on all other coping techniques

Coping/Soothing Kit

- **Goal:** for trauma survivors to try new healthy coping skills and to enhance grounding when triggered.



- Sweet candy
- Stress ball
- Relaxing/calming music
- Bubbles (control breathing)
- Relaxing bath/lotions
- Non-caffeine tea



- Sour candy
- Mazes/word puzzles
- Drawing
- Word Search book
- Play-doh
- Humorous movies
- Sewing, knitting

Providing Psychoeducation on Trauma

- Strategy #1: Provide psychoeducation on the common symptoms of traumatic stress

- Strategy #2: Research the client's most prevalent symptoms specific to trauma, and then provide education to the client. (Ex: individual who was trapped as a result of a traumatic event will more likely be hypervigilant about exits, plan escape routes even in safe environments, and have strong reactions to interpersonal and environmental situations that are perceived as having no options for avoidance or resolution)

Providing Psychoeducation on Trauma

- Strategy #3: List symptoms. After each symptom, ask the client to list the negative and positive consequences of the symptom

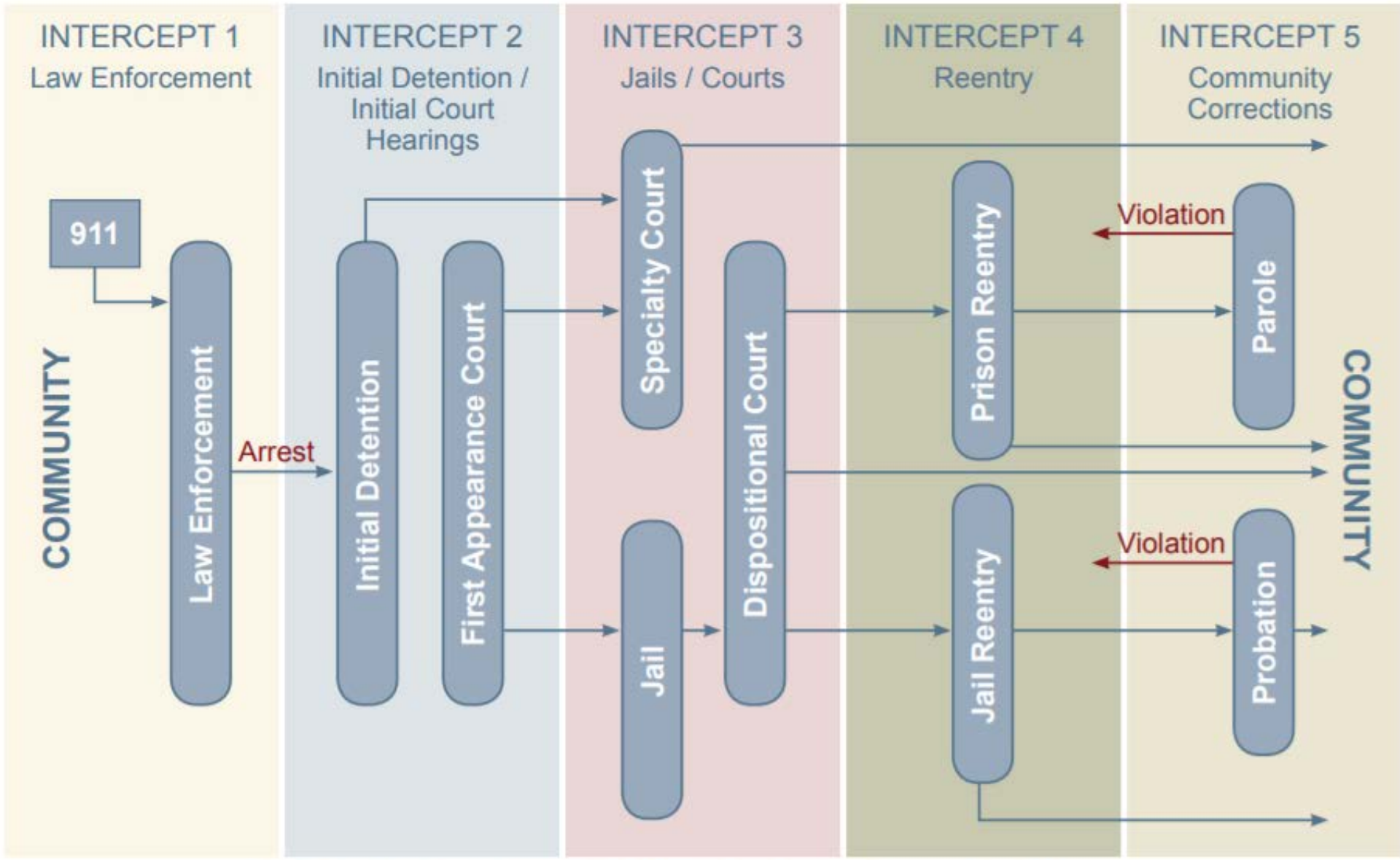
A Trauma-Informed Approach to Engagement

Open ended questions to recognize and focus on building an individual's strengths:

- What are some of the accomplishments that give you the most pride?
- What would you say are your strengths?
- How do you manage your stress today?
- What behaviors have helped you survive your traumatic experiences?
- What are some ways that you deal with painful feelings?
- What coping tools have you learned from your _____ (fill in: cultural history, spiritual practices, friends, family, etc.)?

Trauma-Informed Correctional Care

- TICC results in
  - Controlled healthcare costs and staff turnover
  - Controlled cost of expensive secure mental health housing units
  - Reducing seclusion and restraint
  - Safer facilities and job satisfaction



FIVE INTERCEPT POINTS: Openings for Change

Trauma-Informed Correctional Care

- Interventions/Exercises
  - Trauma-related symptoms, behaviors, adaptations and their function
  - Grounding role plays and demonstrations
  - Practicing verbal trauma de-escalation prompts
  - Demonstrating talking to inmates through pat downs and searches
  - Redirecting offenders and inmates who bring up trauma details

Trauma-Informed Correctional Care

- Incorporate the voice of survivors:
  - Panels of individuals in trauma recovery
  - Videos and films of stories of trauma healing
  - Stories of offenders overcoming victimization
  - Signs of vicarious trauma, supporting co-workers
- Use present-focused cognitive behavioral techniques: “headlines not details”
- Consistency and accountability are essential
- Use manualized treatments if possible

Additional Trauma-Specific Interventions

- Cognitive processing therapy
- EMDR
- Skills Training in Affective and Interpersonal Regulation (STAIR)
- Stress inoculation training (SIT)
- Addiction and trauma recovery integration model (ATRIUM)
- Beyond Trauma: A Healing Journey for Women
- Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD)
- ICBT
- Seeking Safety
- Substance Dependence PTSD Therapy
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM)

SOURCE: SAMHSA, 2014

Self-Care: Recognizing Burnout

- Burnout: exhaustion of physical or emotional strength and motivation usually as a result of prolonged stress or frustration, powerlessness, inability to achieve one's goals

- Compassion Fatigue: the loss of caring for others' emotional pain. Similar to PTSD, except it applies to those emotionally affected by the traumas of others

- Vicarious (secondary) Trauma: similar to compassion fatigue, places the focus on the emotional impact of highly traumatized patients on the therapist. Symptoms nearly identical to PTSD

Self-Care: Recognizing Burnout

- Symptoms of burnout
  - Procrastination
  - Chronic fatigue
  - Cynicism
  - Blaming others
  - Chronic lateness
  - Difficulty experiencing happiness
  - Pessimism
  - Loss of satisfaction in career
  - Giving up on: education, occupation, friendships, marriage, living
  - Addictive behaviors
  - Frequent illness

Self-Care: Recognizing Burnout

- Assessing your Burnout:
  - What populations do you work with?
  - Who/what are your organizational supports?
  - What are your familiar coping strategies?
  - What is your emotional style?
  - What are your vulnerabilities?

It is always critical to seek help and support if you recognize symptoms related to burnout as they could indicate the need for more formal support though your own counseling, EAP, etc.

Self-Care: Develop a Plan

- Personal: tending to physical needs (adequate rest, nutrition), participating in fun activities, identifying relaxing activities to engage in regularly

- Professional: obtain ongoing professional development, recognition by organization of the process of vicarious trauma, developing a professional support network

Self-Care: Develop a Plan

- Eat regularly
- Eat healthy
- Exercise
- Seek regular medical check-ups and care when needed
- Do something you enjoy
- Get enough sleep
- Take time off
- Read for fun
- Identify ways to reduce stress
- Listen to your thoughts, feelings
- Find activities that increase your curiosity

THANK YOU!!

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For additional information on this or other training topics, visit:

www.psattc.org

www.motivationalinterview.org

www.uclaisap.org