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Managing Trauma Reactions in Intensive Addiction Treatment Environments

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SUMMARY. Intensive addiction treatment environments present an outstanding opportunity to help trauma survivors with substance use disorder (SUD). Typically, such environments provide an array of group therapies, close monitoring by staff, and peers with whom to connect. However, only relatively recently has trauma become more accepted as a legitimate focus for work in addiction treatment. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com>*

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Intensive addiction treatment environments present an outstanding opportunity to help trauma survivors with substance use disorder (SUD). Typically, such environments provide an array of group therapies, close monitoring by staff, and peers with whom to connect. However, only relatively recently has trauma become more accepted as a legitimate focus for work in addiction treatment. The old message was, "Get clean and sober first, and then we'll help you with co-occurring issues such as trauma." In some places, this message is still heard. The

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new message, widely recommended at this point (K. T. Brady, 2001; Donovan, Padin-Rivera, & Kowaliw, 2001; Evans & Sullivan, 1995; Miller & Guidry, 2001; L. M. Najavits, 2002a; Ouimette & Brown, 2002; Triffleman, 1998) is, "Let's help you with trauma-related problems as well as SUD." This *integrated approach* (treating SUD and co-occurring mental illness at the same time), is believed to be more helpful both for the SUD and for mental illness. Moreover, a handful of studies thus far have evaluated outcomes for psychosocial treatments that were designed to treat both trauma problems and SUD at the same time. The bottom line? In all of them, clients overall were helped, not harmed (e.g., K. Brady, Dansky, Back, Foa, & Caroll, 2001; Donovan et al., 2001; Morrissey et al., under review; L. M. Najavits, Schmitz, Gotthardt, & Weiss, in press; L. M. Najavits, Weiss, Shaw, & Muenz, 1998; Triffleman, Wong, Monnette, & Bostrum, 2002; Zlotnick, Najavits, & Rohsenow, 2003). Also, the few studies that compared manual-based treatment to addiction "treatment as usual" showed the former to be significantly more helpful (Hien, Cohen, Miele, Litt, & Capstick, 2004; L. M. Najavits, Gallop, & Weiss, under review).

Yet there are notable challenges to help addicted survivors of trauma. Both for clients and for staff, a variety of dilemmas may emerge. In this paper, several broad themes will be identified.

CLIENT DILEMMAS

Clients who suffer from both trauma-related problems and SUD are as unique as their stories. Yet several common dilemmas can be named that appear especially prominent in these clients (and more than in other clients).

Splitting. Both trauma and SUD are characterized by splitting–that is, the tendency for parts of the self to be fragmented or disavowed. Examples of splitting include the following.

- "I want to feel; I don't want to feel."
- "My trauma is everything; my trauma doesn't matter."
- "I want to be heard; I'm afraid of being heard."
- "I want to use substances; I don't want to use."
- "I'm always angry; I never get angry."

In each of these, clients flip from one state to the other, often without conscious control. Indeed, dangerous behavior–such as substance use

and self-harm–may occur when states of mind change without the client's awareness. The client may say, "I was committed to staying abstinent, but then before I knew it, I was sitting at the bar with a drink." Also, clients may have parts of the self that they give names to: the young side, the vulnerable side, the angry side, the adolescent. In severe cases of splitting (as in dissociative identity disorder), the sides of the self may have their own gender, personality, and age, and may not know each other. Why does splitting arise in trauma and SUD? There is no one answer. But clients often describe a family environment in which they were not allowed to have their own thoughts and feelings. They may have been punished or rejected if they tried to express aspects of themselves that parents or others did not want to see. For example, they may have been told never to cry, never to get angry, that their feelings didn't matter, or that the trauma did not really occur. The mind's adaptation to such messages, particularly in children, may be to defensively wall off the unacceptable sides, even to themselves.

Triggering. Both trauma-related problems and SUD are beset by triggering– that is, intense reactivity. Clients may describe their feelings and impulses going from "zero to a hundred in a heartbeat." There is ample physiological research at this point demonstrating that trauma survivors, as well as those with SUD, may have altered reactivity to normal stimuli (Childress, McLellan, Ehrman, & O'Brien, 1987; Yehuda, 2002, 2004). Even once they have achieved improved functioning (and in some cases, no longer meet criteria for actual disorders), the reactivity may continue to occur life-long. For trauma survivors, they may feel as though they are back in a dangerous traumatic situation; they may lose a sense of being in the present. They may have diminished ability to control impulses (to use a substance, to engage in unsafe sex, to hurt themselves such as by self-cutting).

Boundaries. Boundaries are an area of particular difficulty for the addicted survivor of trauma. Particularly if they grew up in a home where addiction, trauma, or both were present, there may be little understanding of how normal boundaries are set and maintained in healthy relationships. They may enact relationships that are too close or too distant. Too-close relationships may be marked by domestic violence, excessive care-taking of others at the cost of self-care, or repeated entry into abusive relationships. Too-distant relationships may be characterized by isolation, inability to open up to anyone, fear of intimacy, and excessive hostility. Clients may also switch between these boundary extremes, either at the same time or different times in their lives. In clinical settings, the client may "pull" for boundary violations, sometimes without being

aware of it. The clinician may feel drawn to extend the standard treatment session, to reveal personal information that they would ordinarily not give, to be overly harsh or overly indulgent, or to engage in sexual activity. For both client and clinician, boundary issues may or may not be fully conscious. When not fully conscious, there is often a feeling of watching oneself behave in ways that one does not want, yet unable to stop it.

Demoralization. Clients with both trauma and SUD may struggle with intense feelings of personal failure. They may be the "revolving door" clients who cannot achieve sustained SUD recovery. Or, they may feel overwhelmed by emotion or trauma memories, even if they are able to consistently sustain abstinence from substances. They may be unclear of who they are, what they like, or whether they are "good" people. Some clients will describe feeling empty or false. They may express confusion, child-like dependency or, the opposite, alienation and inability to connect. However, many factors can influence the degree of demoralization. Clients who experienced a single trauma in adulthood may appear temporarily demoralized but soon may be able to return to the higher functioning they displayed before the event. Clients who experienced multiple traumas (the pattern of most SUD clients with PTSD) (L. M. Najavits et al., 2003) may present with deeper and chronic demoralization features.

Suggestions for Clinicians

Several guidelines may be helpful in addiction treatment settings.

1. *Keep trauma details to a minimum.* Some very caring clinicians may unwittingly "do harm" by asking clients too many trauma details too soon. This may occur as part of assessment, in which generally more information is considered better. Or it may occur as part of treatment where, in trying to truly listen to the client, the clinician may either encourage or allow the client to relate graphic trauma narratives. In general, the safest approach in early recovery is to identify the client's trauma experiences, but to limit this to a phrase or sentence and not more (e.g., "I was raped," "I was physically beaten as a child"). The same holds true for group therapy sessions, in which clients should be able to reveal what their trauma was in a short phrase, if they choose to, but not reveal additional details that can so easily trigger other clients (and even may be too much for the client him/herself). Although it is true that at

some point, the client may benefit from the opportunity to work through memories of trauma, early stage addiction treatment is generally not the time for this due to the client's fragility, their likelihood of leaving the treatment program (i.e., there may not be enough time to fully process trauma memories), and the general lack of individual therapy by skilled trauma specialists. Processing trauma memories is an important method of treatment for some clients, but can potentially induce clinical worsening if done poorly (Keane, 1995; Solomon, Gerrity, & Muff, 1992). Also, there now exists evidence-based trauma-focused treatment specifically designed for early SUD recovery that does not require the client to explore trauma memories. For example, the treatment model Seeking Safety (L. M. Najavits, 2002b) focuses on psychoeducation and coping skills. Such integrated treatment validates trauma, diagnoses and teaches the client about trauma-related disorders (such as PTSD), and teaches a wide range of coping skills that can be applied to both trauma and SUD. Yet it does not require the client to delve into trauma details.

2. *Focus on empowerment.* Twelve-step groups historically focused on males and on SUD without co-occurring trauma. Such models sometimes evolved to a strongly confrontational stance and even in some therapeutic community models, to "bringing the client down a peg" from arrogance to humility. Such methods may work for some clients, but for the addicted survivor of trauma, they may be experienced as overly harsh, judgmental, and even emotionally abusive. In general, an empowerment stance–while still holding the client accountable–is key. Empowerment includes empathy for their trauma, a collaborative stance, a high degree of support, asking the client's permission when possible before intervening (e.g., "Would you like some feedback on that, or not?"), and offering a menu of choices rather than an inflexible treatment program. Yet it is just as important that such empowerment methods not be misinterpreted either by staff or clients as license to just do anything they want, to violate basic program rules, or to harm self or others. The truest empowerment is not blind tolerance, but rather, like a good parent, a balance of support and accountability (L. M. Najavits, 2002b). The clinician can still challenge a client, but does it in a kind and supportive tone. For example, if the client has relapsed the clinician may say, "I'm concerned about you; can we talk about what happened? It is common for trauma survivors to have a hard time staying abstinent, but nonetheless it can be done.

I hope I can help you with that." This type of communication conveys that relapse is not inevitable, is not healthy, and is important to address. The clinician builds rapport non-judgmentally so that the client can freely open up about what happened.

3. *Learn about trauma and related areas.* No matter how skilled the clinician, knowledge of the impact of trauma is key. This means learning the criteria for trauma-related disorders such as PTSD, acute stress disorder, and dissociative identity disorder. It means staying up-to-date on current trauma literature by reading reputable journals and websites. It means being able to respond accurately (based on research) when clients ask questions such as "What is trauma?" "Can I ever recover from PTSD?" and "How common is trauma among people with addiction?" In a recent study (L. M. Najavits & Kanukollu, in press) of trauma training to addiction and mental health treatment programs, clinicians improved significantly in their knowledge of trauma topics. Yet, they also still evidenced substantial gaps in knowledge on such basic questions. Some recommended websites to learn more about trauma include the following.

   - www.ncptsd.org
   - www.ptsdalliance.org
   - www.nimh.nih.gov/HealthInformation/ptsdmenu.cfm
   - www.sidran.org
   - http://coce.samhsa.gov/ (for co-occurring disorders)

4. *Distinguish trauma-informed versus trauma-competent treatment.* Trauma-informed treatment means offering basic trauma education to all staff, from secretaries and security guards through high-level administrators. Trauma-competent treatment means educating fewer, carefully selected staff (generally clinicians) to conduct actual treatment for PTSD and trauma-related problems (Fallot & Harris, 2001; Morrissey et al., under review). Clinicians who seek to become trauma-competent need to become educated about manual-based treatments for trauma/PTSD and may need supervision and formal training (especially if they plan to conduct treatments that focus on exploring trauma memories). It is important to remember that not all clinicians are a good fit for trauma-focused treatment. Sometimes clinicians' own trauma history may make them particularly good at the work or particularly ill-suited for it. For example, some clinicians bring great empathy

to the work informed by their own direct experience of trauma. Other clinicians may not yet have worked through their trauma-related problems and may enact negative countertransference dynamics such as blaming the victim, scapegoating, boundary problems, or excessive caretaking. It may be helpful to obtain clients' feedback about particular clinicians before having them engage in trauma-focused work. Generally clients have a good sense of whether clinicians are sympathetic, helpful, and knowledgeable–or not. Other strategies include supervision in which the clinicians' work is directly observed and peer supervision that allows staff to hear each other's conceptualization of clients.

In sum, intensive addiction treatment provides an excellent opportunity to help clients work on both SUD and trauma at the same time (integrated treatment). Manual-based models that focus on coping skills and psychoeducation are generally the safest approach. The exploration of trauma details is not generally recommended in early stage addiction recovery, except under specific conditions (e.g., clinicians who are trained and supervised in trauma processing models; clients who are able to do the work without become destabilized; and usually individual rather than group modality (L. M. Najavits, 2002b; L. M. Najavits et al., in press)). All addiction treatment staff should be trained in basic trauma education ("trauma informed treatment"), with some clinicians then conducting actual trauma counseling ("trauma-competent treatment"). Principles for working with the addicted survivor of trauma include *keeping trauma details to a minimum, empowerment, learning about trauma*, and *distinguishing trauma-informed versus trauma-competent treatment*. Clients with trauma and SUD problems tend to display problems in a variety of areas, including quite prominently, *splitting, triggering, boundaries*, and *demoralization*. The good news is that such clients can improve (particularly when given evidence-based treatments). Yet, more clinical innovation and research are needed to continue to develop best-practice methods for this population.

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