Northwest Frontier ATTC
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Addiction Messenger

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Trauma Informed Services

Part 1 - The Hidden Aspect of Addiction

"With the recognition that large numbers of men and women receiving services in the mental health and addictions systems are the survivors of sexual and physical abuse, practitioners need to becoem informed about the dynamics and the aftermath of trauma"

Roger D. Fallot

Many individuals struggling with addiction have personal and family histories of trauma including sexual, emotional, and/or physical abuse (Dass-Brailsford, 2010, Najavits, 1998, Reynolds, 2005, Khoury et al, 2010). These traumatic experiences or even witnessing threatening events, often results in significant emotional and physical suffering including low self esteem, a pervasive sense of shame, bodily pain, stomach disturbances, and/or anxiety. In many cases, individuals may try to self-medicate or numb this suffering (McCauley et al, 2010). Eventually these efforts to mask the pain, shame and symptoms results in greater rates of substance abuse disorders, eating disorders, and mood disorders (www.samhsa.gov/nctic). However, people seeking substance abuse treatment may not initially present themselves as requesting treatment for trauma. In addition, the traumatic events they may have experienced, or are currently experiencing, may influence their interactions with treatment providers and their treatment outcomes. This three-issue series of the Addiction Messenger will explore trauma, trauma-informed services, assessment, and treatment approaches.

Traumatic events are usually defined as situations in which a person experiences or witnesses extreme suffering, actual or perceived injury or death, or threat of physical integrity to themselves or others (ISST-D, International Society for the Study of Trauma and Disassociation). Immediate responses to traumatic events can include fear and helplessness and may result in reactions that can potentially interfere with a person's daily living. However, men and women may respond to trauma differently. The type and severity of the trauma experienced may even affect the initiation and use of substances in both men and women. For example, young adult women who have been sexually assaulted are at greater risk for alcohol abuse than young men who have been sexually assaulted (Danielson, 2009). Physical abuse has been correlated with the use of alcohol, cocaine and marijuana, while sexual and emotional abuse are more closely correlated with cocaine and marijuana use (Khoury et al, 2010) (Danielson, 2009). Danielson also reports that lifetime exposure to traumatic events increased the risk for substance abuse among young adults, with young males having reported higher rates of alcohol and drug abuse than females (2009).

There are several types of trauma that can occur when people experience difficult life-changing events. The National Child Traumatic Stress Network (NCTSN) website defines a fairly comprehensive list of types of trauma:

Types of Trauma

- Community Trauma - includes predatory violence (e.g., rape, robbery) and

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Next Issue:

Assessment Tools and Interventions

violence from personal conflicts experienced as a victim or as a witness.

- Complex Trauma - exposure to multiple and/or prolonged traumatic events as the individual is maturing; typically involving psychological abuse, physical and sexual abuse, neglect, and domestic violence.
- Domestic Violence - involves actual or threatened physical, sexual or emotional abuse between adults in, or previously in, an intimate relationship.
- Early Childhood Trauma - experienced by children, aged 0-6, as a result of intentional physical or sexual abuse, domestic violence, natural disasters, accidents, or the loss of a parent/caregiver.
- Medical Trauma - reactions people may have to pain, injury, and serious illness; or medical procedures, surgery, or stressful/painful procedures.
- Natural Disasters - emotional and physical impact of floods, earthquakes, tornadoes, etc.
- Neglect - children or elders not having basic care needs met (e.g., food, shelter, safe environment, etc.)
- Physical and Sexual Abuse - includes physical pain or injury and inappropriate, abusive, illegal, and exploitive sexual behaviors.
- Refugee and War Zone Trauma - exposure to war, political violence, or torture and may parallel those of combat veterans.
- Terrorism - inflicting psychological and physical damage through attacks by individuals and terrorist groups.
- Traumatic Grief - following the sudden and unexpected death of someone which interferes with bereavement.

The links between trauma, adverse childhood events, post-traumatic stress disorder (PTSD) and substance use disorders have been well established (Najavits, 1998, Reynolds, 2005, Khoury et al, 2010). In fact, Najavits (2005) reports that men with PTSD are at particular risk for co-morbid substance use disorders. Further, among males with PTSD it's estimated that 51.9% also have an alcohol use disorder and 34.5% will have a drug use disorder during their lifetime; the rates for females are, respectively, 27.9% and 26.9% (Najavits, 2005). Of course, not every client who experiences trauma will develop PTSD making it important to listen closely to the client's story, experience and symptoms to ensure they are matched with the best clinical services available. Consideration should be given to the factors that are likely to influence the potential occurrence of PTSD and associated mental health symptoms that each client may experience. Below is the National Center on Posttraumatic Stress Disorder (NCPTSD) list of influential factors in the development of PTSD:

- The intensity of the trauma and its duration.
- If the client, or someone close to them, was hurt.
- How close the client was to the event, and the strength of that individual's reaction.
- The client's sense of control in relation to the event, and whether they received help and support after the event.
- Earlier life-threatening events or trauma as a child.
- If the client, or a close family member, has mental health issues.
- Limited support from family and friends.
- Having recently lost a significant other, or had other recent stressful life changes.
- Problematic alcohol use, being a woman, poorly educated and/or young.

Clearly, the disease of addiction itself can be a traumatic experience resulting in the loss of relationships, financial difficulties, homelessness, illnesses, unemployment, and involvement with the legal system and courts. Substance abuse may also increase an individual's vulnerability to trauma. For example, individuals using substances may be more likely to be in dangerous situations where new trauma might occur such as driving accidents, dangerous social situations and arrests (Reynolds et al., 2005).

Trauma-Informed Services

A trauma-informed system is one in which the integral parts of that system have been rethought and assessed with regard for how trauma may have played a part in the lives of clients requesting substance use and mental health treatment and services (SAMHSA webpage **http://www.samhsa.gov/nctic/trauma.asp#care**) (Harris & Fallot, 2001). Furthermore, trauma-informed services are designed to consider and adjust to potential vulnerabilities a traumatized client may have, taking into consideration service delivery approaches that will be supportive and not cause further or retraumatization to the client (Harris & Fallot, 2001). Consequently, the National Center for Trauma-Informed Care (NCTIC) proposes that treatment providers consider changing their theoretical framework from one that views a client as, "What's wrong with you?" to one that asks, "What has happened to you?"

Undoubtedly, client outcomes improve when treatment is facilitated by staff who are trained to assess and treat trauma, and treatment agencies alter services to make clients feel safe. Harris and Fallot suggest that a trauma-informed approach to treatment include a clinician's ability to recognize that clients' maladaptive behaviors may have developed as a way to cope with and adapt to trauma (2001). The core principles outlined by Harris and Fallott as essential in

trauma-informed services include:

- Safety - Ensuring a physically and emotionally safe environment for the client.
- Trustworthiness - Establishing trust and trustworthiness, making client responsibilities and tasks clear, and maintaining appropriate professional boundaries.
- Choice - Emphasizing and encouraging consumer choice and control.
- Collaboration - Focusing on a collaborative approach and sharing of power with the client.
- Empowerment - Stressing the development of client empowerment and skill-building.

The following paragraphs summarize the components of a trauma-informed organization according to Harris and Fallott (2001). The initial organizational component of becoming a trauma informed agency involves administrative support for the integration of knowledge about trauma and violence into all aspects of a treatment agency's functioning. This can be facilitated through the development of formal policy and mission statements and ensuring the availability of resources. Another essential component is the establishment of universal screening of clients for trauma histories and experiences. Universal screening increases the staffs' awareness of trauma issues as they interact with clients and plan their treatment needs and services. Additionally, screenings can increase clients' awareness of the potential impact of trauma and importance of addressing these issues during their treatment. Consistent trauma screening also enhances effective and thoughtful referrals for wrap-around and (recovery management) social services.

Another component of a trauma informed agency involves general and ongoing education, supervision and coaching for all agency staff in the recognition of trauma dynamics. When staff members have a solid understanding of trauma and client coping behaviors, it can help to avoid any inadvertent retraumatization of the client. Consequently, taking time to review agency policies and procedures that could be hurtful or harmful to trauma survivors can improve an agency's sensitivity to clients with trauma histories. Agency practices that might retraumatize or replicate trauma dynamics (e.g., use of seclusion, body searches, not including the client in treatment planning or withholding information from a client) can be modified to avoid occurrence. Overall, it's important that providers are trained to recognize trauma survivors and are sensitive to the client provider relationship as they work to build a healing environment based on safety and trust.

The final component to consider in a trauma informed agency involves hiring practices. An agency may choose to include trauma content in interviews (e.g. questions regarding trauma knowledge and assessment) of prospective staff. Such an approach may aid in identification of potential staff that will be "trauma champions," thus enhancing the agency's creation of trauma informed services. In summary, a trauma informed approach involves a fundamental paradigm shift that emphasizes client choice, recognizes the importance of trust, safety, and is mindful of practices that disempower clients.

Since there is high rate of trauma in substance abusing populations some treatment providers have instituted trauma-informed services. Indeed, the National Survey of Substance Abuse Treatment Services (N-SSATS) reported that in 2009, 62 percent of all substance abuse treatment agencies provided brief mental health screenings for identification of clients in need of trauma services (September 30, 2010). Although, less than half (42%) of addictions treatment agencies provided full mental health assessments to determine a client's history of and exposure to trauma. Facilities that primarily focused on a mix of mental health and substance abuse treatment services were more likely than facilities with other primary focuses to report using trauma counseling "always or often" (30 vs. 16 to 26 percent) (N-SSATS, September 30, 2010).

Therefore, the next issue in this AM series will examine how trauma treatment models and the consistent use of trauma screening and assessment tools may be advantageous for treatment agencies moving toward the implementation of trauma informed services.

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(Continued on Page 4)

(Continued from Page 3)

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NFATTC WORKSHOPS for April - June

Buprenorphine Treatment: A Training for Multidisciplinary Addiction Professionals
April 27, 2011 - Sitka, AK
4-hour Course (14 CE Hours) - designed to provide a broad overview of Buprenorphine, its effects, and the role of nonphysician practitioners in providing and supporting the treatment of individuals receiving this medication.

Cognitive Behavioral Therapy: Part 1
April 28-29, 2011 - Juneau, AK
1.5-day Course (10 CE Hours) - Focuses on building skills in the use of cognitive behavioral therapy for counseling interventions.

Cognitive Behavioral Therapy: Part 2
June 28, 2011 - Honolulu, HI
1-day Course (7 CE Hours) - builds on CBT workshop with an emphasis on both group and individual sessions tailored for a client's Stage of Change.

Clinical Supervision I: Building Chemical Dependency Counselor Skills
April 14-15, 2011 - Honolulu, HI
2-day Course (14 CE Hours) - designed to increase understanding and skill in assessing the clinical skills of counselors in addiction treatment settings and building learning plans for their continued professional growth and development.

Group Counseling & Facilitation Skills
May 3-5, 2011 - Grants Pass, OR
3-day Course (21 CE Hours) - interactive training in how to establish and facilitate productive process-oriented and psycho-educational groups. Content includes stages of group development, resolving conflict in groups, and practicing interventions that facilitate group growth.

Methods for Enhancing Client Motivation in Groups
June 8-9, 2011 - Honolulu, HI
2-day Course (12 CE Hours) - Assumes a basic understanding of group counseling processes and designed to facilitate improvement in client readiness to change. Practice oriented and focused on interventions that address change and improve group process.

Advanced Motivational Interviewing
April 19-20, 2011 - Honolulu, HI
June 1-2, 2011 - Honolulu, HI
2-day Course (14 CE Hours) - designed for those who have had introductory MI training and want to further develop and refine their MI skills in the areas of identifying and eliciting change talk and using strategies to decrease resistance.