

# Substance Abuse, PTSD, and Women

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## Agenda

- PTSD and the DSM
- The Biology of trauma
- The Experience of trauma
- Substance abuse and trauma
- Psychodynamics of Treatment
- Role of Unconscious Processes

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## Agenda (cont.)

- Clinical Dilemmas-for client, therapist, treatment relationship, agencies
- Treatment recommendations
- Questions and Comments

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## PTSD: THREE SYMPTOM CLUSTERS

- Avoidance and numbing
- Re-experiencing
- Hyperarousal

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## Biological and Psychological Responses to Trauma

Six critical issues that affect how people with PTSD process information

- Persistent intrusions which interfere with attending to other incoming information
- Compulsive exposure to situations reminiscent of the trauma
- Active avoidance of specific triggers of trauma related emotions (Lones, A. 2009)

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## Biological and Psychological Responses to Trauma

- Loss of the ability to modulate physiological responses to stress, leading to a decreased capacity to utilize bodily signals as guides for action.
- Problems with attention, distractibility and stimulus.
- Alterations in psychological defense mechanisms and in personal identity. This may change what information is selected as relevant. (Lones, A. 2009)

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## Trauma and Memory

**“Traumatic Memories”**

Victims of trauma report both vivid and vague memories. These memories are often not integrated in the same way as everyday experiences. The memories are fixed, unchanging with the passage of time. (Lones, A. 2009)

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## TRAUMA

- Affective incompetence
- What one cannot feel will deliver itself up repeatedly and painfully until one can feel what one needs to feel
- Injured both agency and attachment

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## Substance Use Disorders and Trauma

Two common pathways lead to the development of comorbid PTSD and SUD

- The SUD proceeds the PTSD. The inherent risk involved in obtaining illicit substances often places the individual in situations that lead to traumatic experiences.
- PTSD precedes the development of SUDS (Lones, A. 2009)

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### Substance Use Disorders and Trauma Commonalities Between PTSD & SUD

PTSD	SUD
■ Prefrontal cortex (PFC) is often “offline”	■ Poor PFC functioning
■ Amygdala activation during symptom provocation	■ Amygdala activation during cue presentation
■ Increase in corticotropin-releasing factor	■ Increase in corticotropin-releasing factor during withdrawal
■ Chronic Distress	■ Chronic Distress
■ Environmental Triggers	■ Environmental Triggers

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## PTSD AND DRUG OF CHOICE


- Avoidance
  - CNS stimulants
    - e.g., amphetamines - increases sociability
- Hyperarousal (irritability/agitation, sleep impairment)
  - sedatives e.g., alcohol

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## PTSD and SUBSTANCE ABUSE

- One reinforces the other - poor coping, high risk behaviors.
- In women, trauma typically occurs first. (Brady)


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## Need for Ongoing Evaluation

- At any given time, the dual problems of substance abuse and trauma can present as depression, anxiety, bipolar illness, psychotic disorder, or a personality disorder.
- As a result, diagnosis and assessment of the individual's central problems requires ongoing evaluation.


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## PTSD and Substance Abuse Treatment: Special Issues for Women

- Trauma and Addiction
  - Mimic one another.
  - Exacerbate one another.
  - Mask one another.
  - Relapse in one can trigger relapse in the other.
  - Create special issues for therapist, patient, and agency.


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## Special Issues for Women

- Socialization as caregivers and 'affiliators' can promote the problem.
- The Four P's
  - Parent
  - Partner
  - Problem
  - Pregnant


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## Women's Issues

- Worries about children as a barrier to tx
- Social stigma reserved particularly for women
  - Fallen woman
  - Bad mother
  - Cultural slurs
  - Beckman's research in 1970's


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## The Psychodynamics of TX

- Clinical Profile
- Unconscious Processes
- Nonspecific variables and the importance of the treatment alliance


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## How a Woman Presents in TX

- Historically, diagnosed with BPD.
- Labeled and/or experienced as "difficult", hard to engage, frequently hospitalized, chronically suicidal, suspicious of the good will, good intentions, and good judgment of therapists.
- In other words, basic trust can't be assumed.
- Often leave treatment prematurely.


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## Psychodynamics: Internal Experience

- A chaotic, unpredictable psychological and physical environment leads to difficulties in thinking, feeling, and acting.
- All or none paradigm dominates.
- Deprivation or indulgence.
- Inability to read danger signals.
- Affective flood or numb.


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## Dynamics of Treatment

- The natural impulse to turn to others for help has been undermined.
- The substance provides a counterfeit comfort.
- It is the maternal object that never disappoints and never abandons.
- The challenge of tx is to lure the person away from the world of substances back to the world of people (with all of its uncertainty and disappointment).


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## Psychodynamics of Tx (cont.)

- Privileging of action over affect.
- Fear that affect will overwhelm and “make me crazy.”
- Profound worries about autonomy.
- Fear that recovery means submitting to the will of another.
- Therapist desire to rescue/abandon.

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## Under the Influence of Unconscious Process: Counter-transference in the Treatment of PTSD and Substance Abuse in Women

MARGARET A. CRAMER, Ph.D.\*

- *PTSD and addiction are a marriage made in the avoidance of unbearable affect; an avoidance that is costly in the resulting traumatic reenactments experienced by patients whose attempts to escape the past keep them ever-more tightly bound to it. Rather than “difficult patients” a more dynamic and intersubjective conceptualization emphasizes the notion of a “difficult treatment dyad.” Vicarious traumatization, unconscious affects about addiction, and pressures within the treatment surround conspire to pull the therapist out of connection with the patient at critical points, and toward sadistic abandonment or collusive indulgence. The concomitant desires to rescue and desert patients create forces for action in the therapist, precisely when what is needed most is the ability to tolerate and contain one’s own and the patient’s affective experience. The pull for action is also felt by treatment systems, eager for “action” that can be measured in “behavioral observables.” Support for the therapist in the form of process supervision can assist the therapist to contain, identify, and acknowledge his/her affective responses evoked in treatment. The therapist is called upon to “grow one’s own heart” through a confrontation with the undeveloped parts of self that are vulner-able to the dynamics of the treatment.*

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## Treatment Dilemmas

- “PTSD and addiction are a marriage made in the avoidance of unbearable affect; an avoidance that is costing in the resulting traumatic enactments in treatment” (Cramer, 2002)
- The dynamics of trauma will come alive in the room within the treatment relationship through
- The Repetition Compulsion and Transference.

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## TRANSFERENCE

- We distort the therapist in ways that are personally meaningful.
- We relive themes, need to believe certain things.
- Importance of neutrality to increase the patient’s projection.


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## REPETITION COMPULSION

- Effort at mastery through familiarity and reversal (Freud)
- An attempt to continue an interrupted relationship (Fairbairn)
- An abortive attempt at self healing (Winnicott)
- As motivational impairment (Developmentalists)
- As interpersonal incompetence (Levenson)

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## REPETITIONS

- Personal creations which hold two separate realities at the same time.
- Represents the scar tissue of interruptions of attachments - Relationships needed for emotional growth.
- Operate in lieu of relationship.


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## WHAT MUST BE REPEATED:

- What the individual needed to feel in order to repair the injury.
- May or may not “reproduce” actual trauma.

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## Unconscious Process

- “Yet what memory repudiates controls the human being. What one does not remember dictates who one loves or fails to love. What one does not remember dictates, actually, whether one plays poker, pool, or chess. What one does not remember contains the key to one’s tantrums or one’s poise. What one does not remember is the serpent in the garden of one’s dreams. What one does not remember is the key to one’s performance in the toilet or in bed. What one does not remember contains the only hope, danger, trap, inexorably, of love-only love can help you recognize what you do not remember.”
- (Baldwin, J.) *The evidence of things unseen.*

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## COUNTERTRANSFERENCE

■ “The failure to feel on the part of the therapist.”

Russell (1994)

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## RECOVERY PROCESS: PTSD and SUBSTANCE ABUSE

- Stabilization and Safety
- Disclosing the Narrative
- Increase Mastery
  - Skills Building
  - Affective Mastery
- Education re: course of illness - cyclical nature - relapse prone

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## TREATMENT RECOMMENDATIONS: SUPPORTIVE INTERPRETATIONS

- Offer interpretations while closing off response expectation.
- Strike while the iron is cold.
- Insure patient activity regarding the context.
- Enhance the holding aspects and containment of the environment.

Pine (1986)

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## PARALLEL PROCESSES

- The occurrence of the phenomena in the supervisory relationship that are the same or similar to the phenomena occurring in the supervisee - client relationship. And in the client's relationship with significant others

Ekstein (1958)

- "Therapists often behave in supervision in the same way the patient behaves in therapy"

Moldansky (1980)

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## THE "CULTURE" OF HUMAN ORGANIZATIONS

- Parallel process can extend to human service organizations
- Treatment settings - Welcome to our family

Predictable patterns:

- problem solving
- conflict resolution
- mutuality, collaboration
- power and hierarchy
- care-giving and self-care

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