Complex Trauma, Mental Health and Addiction: Making the Connection

Christine A. Courtois, PhD, ABPP
Psychologist, Private Practice
Washington, DC
National Clinical Trauma Consultant
Elements Behavioral Health, Promises, Malibu/LA
CACourtoisPhD@aol.com

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Introduction

Trauma, mental health status, and substance abuse are inextricably linked.
Introduction

Substance abuse is implicated in the perpetration of all forms of domestic violence and child abuse.
Introduction

Substance abuse is also implicated in the aftermath of child abuse and domestic violence as well as other types of trauma that result in Posttraumatic Stress Disorder (PTSD) and a range of co-occurring disorders.
Introduction

Substance abuse often becomes a way to cope with the effects of domestic violence, child abuse, and other trauma, and with mental health conditions and disorders especially PTSD.
Introduction

Addiction is a solution to the pain associated with child abuse and other trauma.

It constitutes a form of dissociation--chemical dissociation--and may co-occur with psychological dissociation.
Introduction

Posttraumatic Stress Disorder and other co-occurring mental health issues have a high rate of co-occurrence with Substance Abuse Disorder-SUD.
Introduction

- Ongoing question of precedence of both disorders:
  - Does substance abuse precede PTSD?
  - Does PTSD precede substance abuse?

- Additional question of family and genetics: nature versus nurture
  - Do they co-occur in families?
  - Attachment and developmental studies suggest this as another possibility
  - Other disorders increase the complexity
Introduction

- Repetition phenomena are found in the aftermath of PTSD, SUD, other conditions
- They involve:
  - decline over time, if untreated/unresolved
  - vulnerability to repeated trauma
  - attempts at resolution/suppression
  - high rates of relapse
    - clinical severity and treatment outcome of both are worse than for either alone
  - intergenerational repetition in the family
    - genetics and attachment
    - Teaching/modeling and learning
Introduction

Despite acknowledged co-occurrence:
- clinical programs treat PTSD or SUD but rarely treat both and co-occurrences
- assessment for both is lacking

Addictionologists and traumatologists/other medical and mental health practitioners have worked in parallel
- different and non-intersecting training
- different and non-intersecting settings
- different and non-intersecting goals
Introduction

- Confusion about how to treat PTSD, SUD, co-occurring disorders
  - Sequenced (older perspective)
    » sobriety as first and ultimate priority
  - Integrative/concurrent (newer perspective)
    » treat both sets of symptoms simultaneously

- Increased understanding that treatment modalities for either alone may not work or must be used with caution
Introduction

- The good news:
  - increased recognition of the overlap
  - increased literature and research
  - increased clinical application and development

- The bad news:
  - not yet enough recognition
  - much more research and training are needed
II. Epidemiology

- Trauma is epidemic and endemic in the US and around the world
- Most individuals will have exposure to trauma of one sort or another during their lifetime
- Many have multiple exposures
  - those with complex/cumulative/continuous trauma tend to have much higher exposure
    » revictimization and retraumatization
- Lifetime prevalence of PTSD, US: 8%
Epidemiology

Types of trauma:

- 1. Accidental: “acts of God” and nature or human mistakes
  » disasters, etc.
- 2. Interpersonal violence
  » deliberate/human-induced:
    - stranger
    - acquaintance
    - family
Epidemiology

3. Identity
   - Gender, race, culture, sexual orientation and identity

4. Community
   - Culture, tribe, religion, political group

5. Complex/repetitive/layered accrued/continuous
Epidemiology

- Family (broadly defined): blood relatives, relatives by marriage (i.e., affinal and stepfamilies) and by role (i.e., friend of family)
  - includes all forms of domestic violence, including child abuse
  - usually occurs in the home
  - usually repeats and escalates over time
  - often involves the use of substances and addiction of perpetrator, both partners, others
Epidemiology

- Forms of family violence
  - spousal/partner verbal, physical, sexual assault
  - child verbal, physical, sexual assault and abuse
  - child witnessing of abuse of parents and siblings
  - neglect and abandonment
  - non-protection
  - antipathy and non-acceptance
Epidemiology

- Forms of child abuse
  - emotional
  - physical
  - sexual
  - neglect
  - attachment
  - SUD’s in parents/caregivers

  » parental SUD’s should automatically be considered as forms of interpersonal violence/abuse that are always potentially traumatic to the child

  - involve neglect and attachment insecurity, if not more
III. Trauma

Trauma defined

“...the unique individual experience, associated with an event or enduring conditions, in which the individual’s ability to integrate affective experience is overwhelmed or the individual experiences a threat to life or bodily integrity…”

(Pearlman & Saakvitne, 1995)
Interpersonal Trauma

- Involves *betrayal-trauma*
  - When perpetrator known or related to
- Often involves *institutional trauma*
  - When institution does harm
- Often involves *secondary trauma/second injury*
  - When those who are supposed to help don’t or actually create additional harm
DSM 5 Criterion A: Exposure to a Traumatic Event (A1)

1. Directly experiencing the event(s)
2. Witnessing the event(s)
3. Learning that the event(s) occurred to a close relative or close friend
4. Experiencing repeated or extreme exposure to aversive details of the event(s)

Note: A2 Eliminated in DSM-5 (i.e., fear, helplessness, or horror)
Trauma

Note: in children, this may be expressed instead by disorganized or agitated behavior.
Trauma

Objective factors: Structure of the trauma
- accidental vs. interpersonal
- severity, duration, single vs. multiple incidents
- degree of violence, life-threat
- exposure to death/dying/horror
- damages and losses
- secrecy/forced silence/isolation
- degree of powerlessness
- potential for re-occurrence
- complexity of the stressor
- relationship issues: to the perpetrator and others
- social support and intervention, cultural issues

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Trauma

Subjective factors: Experience of the trauma
- alone or with others
- direct or indirect
- community-based
- moral conflict
- role in trauma and afterwards
- multiple traumatic moments, during and after
- changes in attention or concern
- agency/effectiveness
- peri-dissociation
Trauma

- Subjective factors: Personal
  - Individual resilience and vulnerability
  - Biological/physiological factors
    » genetic predisposition, development
  - Personal development at time of the trauma
    » developmental level
    » attachment history (secure vs. insecure)
    » personality and defenses
    » beliefs, values, abilities
  - Prior and subsequent life events
    » other trauma/revictimization
    » pre- and post-trauma adaptation
Note: most individuals who are seriously traumatized have posttraumatic reactions; not all develop posttraumatic disorders.

Studies suggest PTSD as the outcome in 25 - 30% of all cases BUT serious child abuse trauma may cause the inverse, PTSD in 75% of all cases.
Range of Trauma Reactions

- Peri-traumatic
- Posttraumatic
  - Acute (may resolve, continue, or return)
    » pathological
    » non-pathological
  - Chronic
    » pathological
    » non-pathological
  - Delayed
    » “sleeper effects”
  - Complex: self and life course development
    » acceleration
    » regression/derailment

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Range of Trauma Reactions

- **Acute Stress Disorder**
  - new to *DSM-IV*
  - several prominent dissociative symptoms plus intrusive, avoidant, and hyperarousal symptoms
  - < 4 weeks’ duration

- **Posttraumatic Stress Disorder**
  - > 4 weeks’ duration
  - “classic PTSD”
  - criteria include the definition of trauma and 4 symptom clusters: intrusive, avoidant, cognitive, and hyperarousal
Range of Trauma Reactions

- **Classic PTSD**
  - **Sub-types:**
    » Dissociative: involve derealization and depersonalization
    » Pre-school, up to age 6
  - **Associated feature:**
    » Complex PTSD
Range of Trauma Reactions

- **Dissociation**
  - refers to a disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment
  - is probably the most common defense against trauma in general but especially against childhood trauma
    » in children, the trait/defense may become the state

- **Dissociative disorders almost always occur in response to trauma**-- attachment studies are suggesting an attachment/trauma route
Range of Trauma Reactions

- **Dissociative Disorders**
  - Depersonalization
  - Dissociative fugue
  - Dissociative amnesia
  - Dissociative Identity Disorder
    » related to severe childhood trauma
  - Dissociative Disorder, NOS
    » likely the most common
Complex PTSD

- Criteria derived from reviews of the literature on the aftereffects of child maltreatment
- Developmentally based, integrative diagnosis covering Axis I, II, and III
  » designed to be less stigmatizing than BPD
- Not yet in the DSM, excepted as an associated condition of “classic PTSD”
- Scheduled to be in the ICD-11
- A very useful conceptualization in PTSD/substance abuse work especially for adult survivors of child abuse
Range of Trauma Reactions

- Complex PTSD criteria
  - 1. Alterations in regulation of affect and impulses
  - 2. Alterations in attention or consciousness
  - 3. Alterations in self-perception
  - 4. Alterations in relations with others, including the perpetrator
  - 5. Somatization
  - 6. Alterations in systems of meaning
Range of Trauma Reactions

- Child abuse trauma is associated with at least three main categories of aftereffects (Chu, 1992)
  - Posttraumatic stress symptoms
  - Dissociative symptoms (up to and including DID)
  - Disruption of personality development (often manifested as BPD)
  - Other comorbidity
Trauma Reactions

“Over and over, clinicians and researchers have observed the interactive and synergistic relationships among childhood trauma, posttraumatic stress disorder, substance abuse and violence”

(Lisak & Miller, 2003, p. 73)

These findings give strong support for the cycle of violence and for intergenerational transmission and for more sophisticated intervention.
IV. Comorbidity of PTSD/SUD: New Findings

- The relationship between PTSD/SUD and other mental health concerns is complex
  - each can lead to the other
  - all can arise at the same time
  - their co-occurrence complicates treatment and recovery
  - these patients relapse more often in their treatment
  - they can be a costly burden to the treatment system

- “The suffering associated with SUD/PTSD is alarming” (Brown & Ouimette, 2003, p. 3)
Comorbidity of PTSD/SUD: New Findings

- **Prevalence:**
  - Of patients in substance abuse treatment, 12-34% have current PTSD (some would say these rates are very low)
    - for women, rates are 33-59%
  - For women, typically a history of sexual or physical childhood trauma, for men, combat or crime (men may be underestimated for childhood trauma)
    - likely have complex forms of PTSD

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Numerous co-occurring life and mental health problems:
- PTSD/SUD associated with other Axis I disorders, psychiatric symptoms, interpersonal and medical problems, inpatient admissions, low compliance with aftercare, and low motivation for treatment, homelessness, loss of custody and/or maltreatment of one’s children.
Comorbidity of PTSD/SUD: New Findings

- PTSD is associated with use of severe drugs (cocaine, opioids)
- SUD/PTSD patients with more severe intrusive and hyper-arousal symptoms, poorer coping skills, and more psychiatric comorbidities (e.g., complex PTSD?) may be at higher risk for relapse

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Comorbidity of PTSD/SUD: New Findings

- A causal link has been found between PTSD and SUD:
  - PTSD usually precedes the SUD
  - “...the majority of patients follow a pattern in which the development of PTSD is primary”

(Ouimette, Moos, & Brown, 2003, p. 90)
The role of childhood trauma in addiction

- 7 psychological/psychodynamic characteristics of PTSD/CSA that relate to vulnerability to addiction:
  - trauma reactions
  - trauma shame
  - trauma repetition
  - trauma pleasure
  - trauma blocking
  - trauma splitting
  - trauma bonds (Carnes, 1993)
Three predominant hypotheses:

- **Self-medication**: the individual exposed to trauma develops PTSD and then uses substances to cope with the PTSD symptoms, especially hyperarousal and intrusion/memories.
- **High risk**: drug use is a high-risk behavior that increases individuals’ risk of trauma exposure.
- **Susceptibility**: drug users become more susceptible to PTSD following trauma exposure.

Greatest support *to date* for the self-medication hypothesis:

- more prospective studies are needed.
Co-occurrence of PTSD/SUD: New Findings

Understanding substance abuse from a trauma perspective

- Substance abuse may have begun as an attempt to cope with primary trauma or with its short and long-term aftereffects
- May have been modeled and learned in the family; SUD may have been traumatic
- Substance abuse may persist as a way to self-soothe when trauma symptoms increase
- Primary trauma may trigger the development of psychiatric symptoms or relationship patterns than then trigger substance abuse
Co-occurrence of PTSD/SUD: New Findings

- A major implication of this finding:
  “Although both disorders need to be treated, change in PTSD symptoms is the more important factor in the remission of both disorders” (Ouimette, Moos, & Brown, 2003, p. 93)

- Co-occurring Disorders must also be treated
The question is when in the course of treatment to address substance use and when to address PTSD and other conditions:

- sequential (old): treat the substance abuse first
- concurrent (new): treat both simultaneously
  » likely does not happen much in practice
Treatment of PTSD/SUD: New Findings

- treatments used for PTSD-alone, SUD-alone, or other conditions alone may not work for combined treatment
  (e.g., behavioral exposure, twelve-step and self-help groups, benzodiazepines)
- must be aware of symptom substitution
- new treatments are being developed and tested
Common clinical dilemmas (Najavits, 2002)

- Which disorder do I treat first?
- Should the patient talk about painful trauma memories during treatment?
- Should the patient be required to attend AA?
- How patients stay in treatment?
- How do patients stop relapsing?
Practice recommendations for PTSD/SUD (Ouimette, Moos, & Brown, 2003, pp 108-110)

- All mental health patients should routinely be screened for traumatic stress experiences and PTSD
  » assessment is crucial
  » many brief instruments
  » assessor must be sensitive

- SUD/PTSD patients should be referred for concurrent trauma/PTSD treatment or for psychological treatment with the recommendation that trauma/PTSD issues be addressed
Practice recommendations (Ouimette, Moos, & Brown, 2003, pp 108-110)

- SUD/PTSD should be referred for concurrent participation in self-help groups and, when indicated, for family treatment.
- Providers should offer SUD-PTSD patients continuing outpatient mental health care.
- Providers should be aware of gender and culture-related methods that help attendance.
Treatment of PTSD/SUD: New Findings

- Practice recommendations for PTSD (ISTSS, Foa, Keane, & Friedman, 2000, 2009); J of Clinical Psychiatry, 1999)
  - CBT: PE and CPT; EMDR
  - psychopharmacology (selective, with consideration of comorbidity)
    » SSRI for depression
    » anxiolytic (? for SUD patients)
    » medication for sleep
  - education
  - treatment of comorbidities, including SUD
Effective Treatments for CPTSD

- PE (Foa) and CPT (Resick), applied later
- EFTT: Emotionally Focused Trauma Treatment (Paivio & Pascua-Leone)
- EMDR: in stages, w/ resourcing first; numerous protocols (Shapiro)
- IRRT: Imagery Re-scripting and Reprocessing Therapy (Smucker & Dancu)
- EFT: Emotionally-Focused Treatment for Couples (Johnson)
- Some group models: (Courtois; Lubin & Read; Mendelsohn et al.)
- “Hybrid” short-term models:
  - STAIR: (Cloitre)
  - TARGET: (Ford)
Recommended Treatments for CPTSD
ISTSS Complex Trauma Task Force Survey, JTS, 2011

- "First line" approaches:
  - Emotional regulation
  - Narration of trauma memory
  - Psych-education and cognitive re-structuring
  - Anxiety and stress management
  - Interpersonal/relational strategy

- "Second line" approaches:
  - Meditation/mindfulness

- Customized interventions tailored to specific sx
- Course and duration of treatment unclear
Recommended Treatments for CPTSD
ISTSS Complex Trauma Task Force Survey, JTS, 2011

- **Sequenced:** assessment & 3 (or more) main phases, each with major treatment tasks
  - **Assessment & pre-treatment**
  - **Phase 1: Safety and Stabilization:**
    » emotional regulation and other skill-building, educational-cognitive approaches, building of the treatment alliance
  - **Phase 2: Remembrance and Mourning:**
    » emotional and memory trauma processing, emotional integration & resolution, narrative dev., meaning-making
  - **Phase 3: Life Reconstruction:**
    » Reconnection with others, present and future functioning
Sequenced Approach to Treatment

- Sequenced model first developed by P. Janet
- Recommended for DD’s
- Recommended for complex trauma

Endorsed in:

- Best practices chap by Courtois, Ford & Cloitre (2009)
- ISSTD Guidelines for DID (2011)
- Australian ASCA Guidelines (2012)
- Joint ISSTD-Division 56 (APA) Guidelines (forthcoming)
PTSD/SUD treatments have a lot in common and much to offer each other

- focus on the whole person
- attention to bio-psycho-social and spiritual issues
- stages of treatment/stages of recovery
- treatment of co-addictions, comorbidities
- attention to and management of caregiver response: careful boundary management and self-care
Shared principles of PTSD and SUD/other mental health treatment:

- SAFETY
  - harm reduction/safety planning
- educate patients: cognitive and behavioral strategies
- hope/optimism
- patient empowerment wherever possible
- treatment framework/boundaries
- treatment sequencing
- strengths-based
- attention to reactions of treater
Treatment of PTSD/SUD: New Findings

- Careful attention throughout treatment to the seven psychological/psychodynamic characteristics of PTSD/CSA that relate to vulnerability to addiction:
  - trauma reactions
  - trauma **shame**
  - trauma repetition
  - trauma pleasure
  - trauma blocking
  - trauma splitting
  - trauma bonds  (Carnes, 1993)
Treatment of PTSD/SUD: New Findings

- Sequenced treatment for trauma: Three primary phases:
  - 1. Initial: safety and stabilization
    » self-management of PTSD/DD symptoms
    » sobriety
  - 2. Middle: Processing of the trauma
    » Graduated or prolonged exposure to process the trauma; use of specialized techniques
  - 3. Late: Reconnecting with self and others
    » Learning to live life differently
Treatment of PTSD/SUD: New Findings

- Foundations of trauma treatment:
  - The essential role of **safety** (in general and specifically from additional violence, abuse and re-traumatization) and issues of self-care
  - The essential role of **informed consent and patient education**
    » teaching about trauma, not only about dysfunctional families
  - The essential role of **skill-building**, especially affect regulation and self-management skills
  - The essential role of **empowerment**
Treatment of PTSD/SUD: New Findings

- Inpatient (Bollerud, 1990)
- Co-addictions and trauma (Carnes, 1993)
- Seeking Safety (SS, Najavits, 2002)
- Covington materials on trauma and addiction
- Addiction and Trauma Recovery Integration Model (ATRIUM, Miller & Guidry, 2001)
- Assisted Recovery Trauma and Substances (ARTS, Triffleman, Wong, Monnette, & Bostrom, 2002)
Summary

- There is cause for optimism in the treatment of PTSD/SUD/co-occurring mental health and psychosocial conditions associated with child abuse trauma
- New diagnostic conceptualizations are especially pertinent (i.e., complex PTSD)
- The integration of research and treatment is developing rapidly
- More to come...
Resources

◆ ISST-D.org
  - look for 9 month-long courses on the treatment of DD’s--various locations internationally, nationally, and on-line beginning Sept-Oct

◆ ISTSS.org

◆ www.ChildTraumaAcademy.org

◆ NCPTSD.va.gov (info and links)

◆ NCTSN.org (child resources)

◆ Sidran.org (books and tapes)

◆ APA Div. 56: Psychological Trauma—new!! (traumadivision@apa.org) Please join!!