Trauma and Substance Misuse

CAMDEN INTEGRATED DRUG AND ALCOHOL SERVICES

Issue 1 February 2017

This is the first of a series of Camden CGL internal newsletters sharing research, views and experience on the broad subject of trauma. In this edition we look at what it is and why it is relevant to us, and at some key developments and initial approaches to support clients.

What is psychological trauma?

Psychological trauma is a type of harm that can result from an event or events that the victim finds so severely distressing that it exceeds their ability to cope, or to integrate the emotions surrounding the experience.

Experiencing an event or repeated events, in which one's own life is seriously threatened, or a loved one's life is seriously threatened or lost, or witnessing an event where someone's life or wellbeing is seriously threatened, can have a severe impact on our ability to feel safe, to trust the world or other people, or to feel joy.

Events such as natural disasters, war, community violence, threatened or actual physical assault (eg, domestic violence, rape, other assault), childhood abuse or neglect, or a work or car accident may result in trauma.

Natural reactions to such experiences may be to distrust others (including us, as service workers), and to numb related thoughts and feelings, such as through substance misuse or with depression. Often, energy and motivation sink as the body focuses its resources to deal with the threat that it perceives as ongoing.

Many people experiencing horrendous events recover in time without feeling overwhelmed or needing professional help. Social networks, a sense of purpose, spirituality, self-care and a positive outlook can allow many people to process and integrate the experience and function as before. While maybe feeling sad, fearful or tired at first, many people also experience positive feelings some of the time as they gradually recover.

The ability to recover can depend on, for example, the severity or frequency of the event, the age at which it is experienced, support available and whether the event(s) was caused by a trusted person, eg, a parent or caregiver.

Inside...

Why focus on trauma?

An awareness of trauma is especially relevant to drug and alcohol recovery services for several reasons:

- those who have experienced traumatic events are more likely to use drugs and alcohol.
- those who misuse substances are more likely to experience a traumatic event as a result of the use (eg, verbal/ physical/sexual abuse, serious illness, accidents).
- dependent users may be less able to cope with a potentially traumatic event as a result of the functional impairments associated with problematic use.

(From *National Child Traumatic Stress Network, USA, 2008)*

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Symptoms of trauma

"Trauma has nothing whatsoever to do with cognition. It has to do with your body being reset to interpret the world as a dangerous place."

Bessel van der Kolk

Trauma symptoms may be physical, emotional, relational and behavioural. At times emotions may feel overwhelming; at other times it may be difficult to feel anything.

Symptoms may include:

- Exhaustion
- Dissociation, avoidance, numbing, depression
- Feeling sad or hopeless
- Feeling disconnected and/or withdrawing from others
- Confusion, haziness, difficulty concentrating
- Anger, irritability, mood swings
- Heightened emotions
- Guilt, shame, self-blame, worthlessness
- Flashbacks, nightmares, intrusive thoughts
- Increased anxiety/fear
- Shock, denial, disbelief
- Hypervigilance (eg, jumping at noises, watching people and surroundings intensely)
- Addictive behaviours, eg, self-harm, drugs/alcohol, compulsive sex
- Medically unexplained physical pain, eg, headaches, stomach problems, earache, toothache

It can be helpful to let people know that these are normal reactions to the abnormal situation that they have experienced.

Next time...

- Can MDMA heal trauma?
- Promising body therapies
- Avoiding staff burnout
- Personal experience of trauma

Selected highlights in psychological trauma studies

Flashbacks can feel like a film strip of the events repeatedly playing in your head.

As long as there have been natural disasters and wars, commentators have noticed their effects on the psyche.

However, the late 19th century marks the start of serious scientific trauma studies.

1889: Pierre Janet, a psychiatrist in Paris, wrote "hysterical symptoms are due to subconscious fixed ideas that have been isolated and usually forgotten. Split off from consciousness – 'dissociated' – they embody painful experiences, but become autonomous by virtue of their segregation from the main stream of consciousness" (*Bliss, 1986*)

1915: C.S. Myers used the term "shell-shock" in reference to traumatised soldiers returning from WWI.

1939-1975: WWII, Holocaust, atomic bombings; Korea and Vietnam wars. "Shell-shock" is renamed "Combat Stress Reaction" or "battle fatigue."

1980: Post-traumatic stress disorder (PTSD) is included in DSM-III, the standard US manual of mental disorders. This validated the concept that a traumatic event, rather than an inherent individual weakness, could be the cause of a mental disorder.

1990s: "Gulf War syndrome" identified.

1992: Harvard professor and psychiatrist Judith Herman published *Trauma and Recovery*, a classic study on the psychological consequences of traumatic life events.

First step in managing trauma: "Applying the Brakes"

Babette Rothschild, MSW, a U.S. body-psychotherapist, stresses that remembering the trauma, while useful for some people, is not essential for healing.

She emphasises the importance of first developing a strong relationship with the client—in which the client feels truly safe and able to proceed at their own pace—which may take months or even years. Nonetheless, Rothschild stresses that this is a vital phase, not to be abbreviated.

Rothschild describes her approach to trauma therapy as being similar to how she first taught someone to drive. Concerned for her own safety in the car, she realised that the first thing to teach the new driver was how to stop confidently, quickly and safely.

In the same way, Rothschild teaches clients who want to heal trauma how to feel in control and stop becoming overwhelmed by their emotions. For example, they might learn to pull themselves out of the memory by picturing something safe or doing a specific physical movement unrelated to the memory.

Rothschild promotes mindfulness as a way of helping clients to be aware of emotions and their physical sensations in the now.

This then allows a client to speak about the trauma (or not) and release difficult emotions gradually, like releasing gas from a shaken-up Coke bottle.

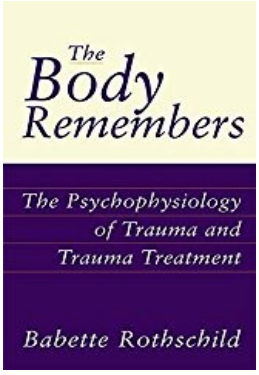
Judith Herman, PhD, distinguished between single-incident traumas (eg, car accidents, terrorist attacks) and complex traumas resulting from prolonged, repeated events (eg, child abuse, torture, domestic violence).

She offers a three-stage treatment sequence:

1) regain sense of safety, eg, through a therapeutic relationship, medication, relaxation exercises or a combination of these.

2) active work on the trauma, fostered by that secure base, and employing various psychological techniques.

3) a new post-traumatic life, possibly with growth and new meaning gained from the experience.



The Body Remembers (2000), Babette Rothschild

> "It is not necessary to remember trauma and revisit and relive it in order to recover from it."
>
> *Babette Rothschild*

What therapies does the NHS offer?

The NHS offers psychotherapy for patients diagnosed with PTSD. In severe or persistent cases, antidepressants may also be prescribed. The NHS can offer 8-12 sessions of TF-CBT or EMDR.

Trauma-focused cognitive-behavioural therapy (TF-CBT, also known as "exposure" therapy) involves increasingly "exposing" a client to their fears or memories and helping them to manage any distress. The therapist might help to "identify any unhelpful thoughts about the experience" (eg, that you are to blame for the event or that it will re-occur). They may also support a client to gradually restart any activities recently avoided, eg, driving a car if the person had an accident.

Eye movement desensitization and reprocessing (EMDR): While the reasons for its effectiveness remains something of a mystery, this has proven a highly effective, rapid therapy for many people. While the client speaks about the trauma the therapist trained in this approach simultaneously creates specific movements that, it is believed, allow the brain to integrate the traumatic memory.

Several studies showed EMDR to be highly effective for traumas experienced in adulthood, such as for soldiers, adults who had car accidents, etc. However, it was much less effective for childhood traumas.

EMDR is one of the trauma therapies offered by the NHS.

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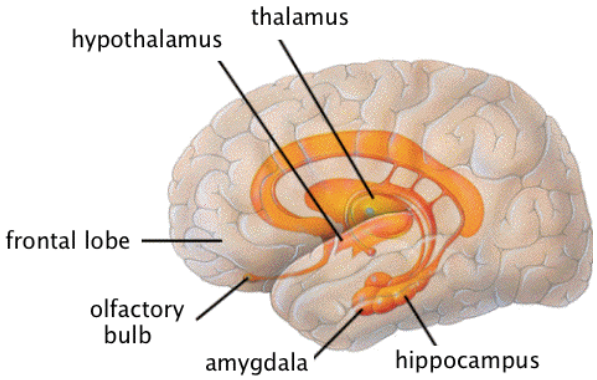
CAMDEN INTEGRATED DRUG AND ALCOHOL SERVICES/SOME SPACE

Your brain on trauma

It appears that flashbacks and other symptoms of trauma are related to how the brain creates and stores memories of a traumatic event.

The thalamus acts as a gatekeeper, "reviewing" sensory information entering the brain (from all the senses except smell) and relaying it to (and later "retrieves" it from) the area in the brain connected with that sense.

The limbic system is a vital part of the brain for processing emotion and forming and processing memories. It includes the hypothalamus, the hippocampus, the amygdala, and several other nearby areas around the thalamus. It appears to have evolved in early mammals to control fight-or-flight responses and react to both pleasurable and painful sensations. The hippocampus allows us to retrieve learned information and memories. However, our emotions also affect how we store information.



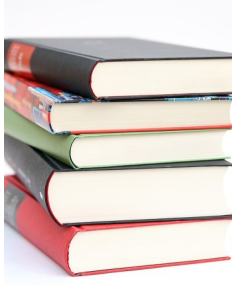
The hippocampus joins bits of information, creating synapses to make new memories. It prioritises those with a high emotional content.

The amygdala is involved in forming and storing memories of events associated with emotions , including fear. It conditions the brain to define and respond appropriately to an incoming stimulus. It retrieves information on how we felt when events happened so that we are alert to risks when we sense something similar to a previous scary or dangerous event.

Processing trauma
When we experience traumatic events, the fight/flight/freeze survival response takes over: the amygdala signals the body to produce more adrenaline and cortisol and raise blood pressure so that we have the energy and strength to fight or to quickly flee.

The sights, sounds, emotions and physical sensations experienced at the time of a terrifying event can remain 'unprocessed' in the brain, meaning that the body remains in fight fight/flight/freeze mode. Similar sensations, sounds, locations, dates, etc., can "trigger" the sense that we are reliving the horrific experience, both when awake and in nightmares.

Research indicates that the stronger our emotional response to an event at the time, the easier it generally is to access from long-term memory—ie, the stronger the memory will be.



Further reading

- De Zulueta, F. (2006). *From Pain to Violence: The Traumatic Roots of Destructiveness*
- Herman, J. (1992). *Trauma and Recovery: The Aftermath of Violence - From Domestic Abuse to Political Terror*
- Levine, P. (1997). *Waking The Tiger: Healing Trauma - The Innate Capacity to Transform Overwhelming Experiences*
- Rothschild, B. (2002). *The Body Remembers*
- Van der Kolk, B. (2014). *The Body Keeps The Score*

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