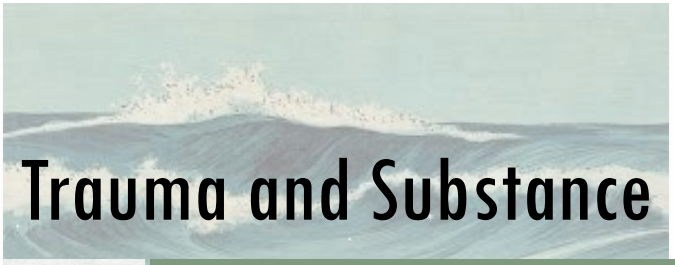


Trauma and Substance Misuse

CAMDEN INTEGRATED DRUG AND ALCOHOL SERVICES

Issue 2 June 2017

This is the second in a series of Camden CGL internal newsletters sharing research, views and experience on the broad subject of trauma. In this edition we look at ***some controversial research into trauma and addiction, promising body therapies, and care for staff working with trauma, to avoid burnout****.*

Non-verbal therapies

Is it necessary to talk about the traumatic experience—and risk potentially retraumatising clients—or is it possible to heal the trauma without them emotionally re-experiencing the horrific event(s)?

Therapies such as psychoanalytic and EMDR (see previous edition) are likely to focus on recounting details of an experience to a therapist. Humanistic/person-centred approaches do not ask that the client relate the event(s), although the client may of course choose to speak of them. Either way, the client can experience and learn to manage, in therapy, some of the feelings associated with the traumatic event.

Treatments that specifically aim to heal trauma were developed initially in response to post-traumatic stress disorder (PTSD), which was deemed a response to the (usually adult) experience of a traumatic event. Evidence indicates that different clients respond differently to different therapies.

Flashbacks may occur when the senses are triggered in the same way that way that they were around the time of the event—eg, by sounds, by something looking similar, or when similar feelings arise in different contexts.

As Babette Rothschild (2010) writes:

> *"Inviting a client to actively engage one or more of the five senses when they feel overwhelmed by flashbacks, sensations and emotions can support them to manage these feelings in the present, ultimately allowing the mind and body to realise that they are now safe."*

Alternative therapies such as ear acupuncture, yoga and mindfulness that cgl Camden offers, also allow us to be aware of body sensations in the present.

The following suggestions for sensory grounding are adapted from Christiane Sanderson, © 2016. Invite a client to focus on one or two of the following:

Touch – pebble, soft toy, fabric, chair

Sight – identify three things in the room, shift gaze

Sound – songs, poem, nursery rhyme, humming, chanting

Smell – scent, flower, perfume, herbal tea bag

Taste – food & drink, e.g., tea, raisin, orange, lemon

Inside…

Trauma and Substance Misuse

The word **"petrified"** - derived from Latin and Greek - literally meant "turned to stone", which reflects the idea of freezing in reaction to fear.

A personal experience of trauma

For years, Sally had considered herself a strong, confident person who could deal with pretty much anything, so when she found herself sobbing unpredictably in public and unable to sleep well for weeks on end, she knew something was wrong.*

Sally: After dad died, it felt like anything would make me cry – the tears would start when I woke up, or made a cup of tea, or in the supermarket. I tried to hide it – sunglasses in winter, or saying I had hayfever. So embarrassing. The kids could tell. Even a TV movie would set me off. I was grumpy, exhausted and really angry at the world all the time, even at the kids.

My younger sisters and I learned when to get away from my dad. You could feel mum's anger and anxiety if he was late home from work. When he finally got in, smelling of beer and cigarettes, his arms and legs didn't quite belong to him. We knew it was all going to kick off.

Mum would get this high-pitched voice, trying to calm him down, and he would start on her. Inevitably, he would end up punching everything around him, mum included. I couldn't stop him.

Funny how I remember that in detail – the sounds, smells, images – when other memories – school, other kids, holidays – seem so fuzzy.

When I had my own kids, it was tough, but I worked really hard to make sure we had a "good" life – music lessons, sleepovers, swim team, football, drama groups, theatre trips.

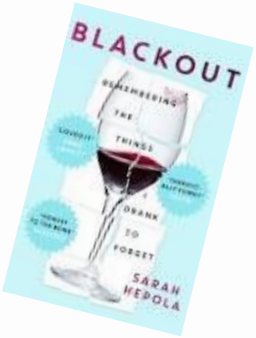
When dad died, I thought I'd feel some relief, but I got all these angry and sad feelings that I tried to ignore by filling every moment. It was exhausting and I just couldn't keep going like that. Then my partner of two years had a few too many one night and threatened my eldest. I threw him out and changed the locks. I told the kids they were safe. A few days later, I was a wreck.

I finally saw my GP who referred me to a therapist. I wasn't sure about it, but it worked! It didn't erase those scenes, but it feels like, rather than them invading unexpectedly, I can now look at them only if and when I choose to.

**This story draws on accounts of different people's experiences of trauma.*

Further reading

In Sarah Hepola's memoir, she explains, among other things, what happens to the brain in a blackout: that the hippocampus (the part that helps make memories) shuts down when blood reaches a certain alcohol content. Consequently, it does not make memories during that time.



Hepola, S. (2015). *Blackout: Remembering the Things I Drank to Forget*. London: Two Roads.

Elizabeth Loftus's engaging TED talk about her over 50 years studying human memory.

Loftus, E. (2013). *How reliable is your memory?* (TED talk) https://www.ted.com/talks/elizabeth_loftus_the_fiction_of_memory

Can MDMA cure high anxiety and PTSD?

Research at Imperial College London and in Charleston, South Carolina, USA, into the neurological effects of MDMA may offer hope in treating anxiety and PTSD.

UK trials

In a small 2012 trial of healthy volunteers, Professor David Nutt and Dr Robin Carhart-Harris at Imperial found that MDMA reduces blood flow in the limbic system (part of the brain linked to emotion and memory).

The researchers caution that they would have to do larger studies in PTSD patients to see if there are similar effects.

In an MRI scanner, volunteers recalled favourite memories as "more vivid, emotionally intense and positive" and rated their worst memories less negatively after MDMA, compared to placebo. The MRI brain scans reflected this, with the MDMA appearing to reduce the emotional impact of painful memories.

The team suggests that this could help PTSD patients speak about traumatic experiences in therapy without such intense, painful feeling.

USA trials

In Charleston, patients underwent 12 weeks of psychotherapy, including three eight-hour sessions in which they took MDMA. Patients said their symptoms more than halved on average and two out of three no longer even met criteria for PTSD. Follow-up tests found that improvements lasted over a year after the therapy.

Based on those results, in November 2016 the US Food and Drug Administration allowed Phase 3 clinical trials of MDMA, the last stage before possible approval as a prescription drug (as a small part of treatment), by 2021.

Sources:

http://www3.imperial.ac.uk/newsandeventspggrp/imperialcollege/newssummary/news_17-1-2014-11-35-46

http://www.nytimes.com/2016/11/29/us/ptsd-mdma-ecstasy.html?_r=0

Patients said their symptoms more than halved on average and two out of three no longer even met criteria for PTSD.

UCL: Ketamine may erase alcohol-related memories

Dr Ravi Das at University College, London (UCL) in Camden borough is researching whether ketamine might alter alcohol-related memories that can trigger excessive drinking. Such memories of drinking might be triggered by unavoidable things in the environment, such as the sound of glasses clinking, the smell of a barbecue or people laughing on a sunny day.

It seems that, when we recall something, the memory's neural "code" is briefly disrupted and can be slightly altered before being stored once more.

Scientists believe that a single dose of ketamine, taken just when the memory is unstable, might block NDMA, a chemical string needed to make memories, and that this can offer a brief opportunity to modify the memory.

Participants in the study drink well above recommended guidelines. In the trial, their alcohol-related memories are triggered by putting a glass of beer in front of them. The researchers then surprise them to disrupt the memories, and give them ketamine or a placebo. (The way they surprise participants is not revealed, so as to maintain the surprise effect.) The trial will check next year if participants' drinking behaviour has changed and if there is a difference between those who took the placebo and those given ketamine.

Sources

- *https://www.ucl.ac.uk*
- *The Guardian, Jan 24 2017, by Hannah Devlin*

Next time...

- *Trauma in childhood: the Adverse Child hood Experiences studies*
- *The relationship between trauma and "personality disorders"*
- *Post-traumatic growth: grieving loss, creating a new future.*

Trauma and Substance Misuse

CAMDEN INTEGRATED DRUG AND ALCOHOL SERVICES/SOME SPACE

Staff—Reducing your risk of vicarious trauma

Vicarious trauma

is a process of change resulting from empathic engagement with trauma survivors. While it tends to develop over time it can also result from a single incident. It can resemble symptoms of post-traumatic stress.

Anyone repeatedly exposed to other peoples' pain and suffering, can be negatively affected by seeing and hearing their stories. This is a normal reaction to the experience of caring for others in pain.

Common signs of vicarious trauma include:

- Persistent anger or sadness about the client's experience or situation
- Outside of work, thinking about a client a lot of the time, having ideas about rescuing the client or having trouble maintaining boundaries with the client
- Persistent feelings of hopelessness, pessimism or worthlessness
- Doubting your abilities or feeling guilt or shame at not being in their situation or at feeling unable to help them
- Detaching—avoiding engaging with the client and their story; over-working, isolating from others; increasing drug/alcohol intake
- Increased high-risk behaviours, e.g., unprotected sex, driving fast
- Questioning core beliefs about yourself and the world.

> "Repeated exposure to people's suffering can diminish the helper's trust in humanity and often leads to a heightened sense of vulnerability"
>
> *- Judith Herman, 1997*

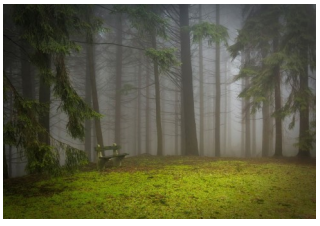
Self-care

How can you reduce your risk of vicarious trauma? You are most likely well aware of and already doing some or all of these things, and teaching them to clients! But as a reminder:

- Self-awareness—recognise the above signs
- Debrief as needed and make use of supervision and training opportunities
- Take breaks and time off when needed, and after work, do something different, fun and relaxing
- Seek social support from people whose company you enjoy
- Focus on what you can do, not on what you cannot change
- Eat well, do some form of exercise, get enough sleep
- Don't take on responsibility for your patients' wellbeing but supply them with tools to look after themselves
- Try to have a balanced caseload - a mix of more and less traumatised clients, victims and non-victims.

Organisations supporting traumatised clients can help reduce the risk of their staff experiencing vicarious trauma by, for example, ensuring that staff have manageable caseloads, take holidays and sick leave and do not work excessive hours.

Organisations should provide regular supervision; education about self-care, vicarious trauma and burnout; and opportunities to debrief and process concerns and difficult material; as well as creating an atmosphere that normalises the feelings and plans for and helps to reduce vicarious trauma in the workplace.



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