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Trauma Engaged Substance Use Disorder Treatment

TURNING POINT COUNSELING SERVICES
Today's Presentation

• ACES create the space for addiction and mental health problems to come in.
• Defining trauma.
• What happens to the brain after trauma?
• What happens when a traumatized client stops using drugs including alcohol?
• Treating trauma in a SUD population
<table>
<thead>
<tr>
<th>ABUSE</th>
<th>NEGLECT</th>
<th>HOUSEHOLD DYSFUNCTION</th>
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<tbody>
<tr>
<td>Physical</td>
<td>Physical</td>
<td>Mental Illness</td>
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<td>Emotional</td>
<td>Emotional</td>
<td>Incarcerated Relative</td>
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<td>Sexual</td>
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<td>Mother treated violently</td>
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<td>Substance Abuse</td>
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<td>Divorce</td>
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Compared with people with no ACEs, those with 4+ ACEs are:

2. times more likely to currently binge drink and have a poor diet
3. times more likely to be a current smoker
5. times more likely to have had sex while under 16 years old
6. times more likely to have had or caused an unplanned teenage pregnancy
7. times more likely to have been involved in violence in the last year
11. times more likely to have used heroin/crack or been incarcerated

Number of ACEs and Lifetime Suicide Attempt

Attributable Risk from ACEs

Preventing ACEs in future generations could reduce levels of:

- **Early sex (before age 16)** by 33%
- **Unintended teen pregnancy** by 38%
- **Smoking** (current) by 16%
- **Binge drinking** (current) by 15%
- **Cannabis use** (lifetime) by 33%
- **Heroin/crack use** (lifetime) by 59%
- **Violence victimisation** (past year) by 51%
- **Violence perpetration** (past year) by 52%
- **Incarceration** (lifetime) by 53%
- **Poor diet** (current; <2 fruit & veg portions daily) by 14%

Dr. Gabor Mate

• “Not all addictions are rooted in abuse or trauma, but I do believe they can all be traced to painful experience. A hurt is at the centre of all addictive behaviours.”

• “As we’ll see, the effects of early stress or adverse experiences directly shape both the psychology and the neurobiology of addiction in the brain.”

• Gabor Mate, *In the Realm of Hungry Ghosts: Close Encounters with Addiction*
Defining Trauma/Traumatic events

• All trauma is real, and all trauma happens in the brain.
• Trauma affects different people differently; how it affects a person depends on their resilience and risk factors.
• A traumatic memory is typically outside of our ability to remain emotionally connected to the situation. So we begin a process of distancing ourselves from the experience through a variety of different ways such as, dissociation, avoidance, or other ways of not dealing with what happened.
Types and levels of trauma

- Post Traumatic Stress Disorder (PTSD)
- Subclinical PTSD
- Developmental Trauma
Emotional brain

The **amygdala** is responsible for “fight or flight or freeze”.

Another part of the brain is the **hippocampus**, which is just above the amygdala.

The hippocampus applies context to the situation (emotional stamp), and helps to regulate the amygdala and other functions in the brain.

**Prefrontal cortex** is responsible for emotional regulation, specifically triggered by the amygdala.

*Restak, 1988*
What happens physically to the brain after psychological trauma?

• Activity in the Amygdala increases.
• Decrease of activity in parts of the Prefrontal Cortex.
• Increased dopamine and norepinephrine levels.
• Decrease in serotonin.
• Large effects in the memory processing areas of the brain.
• The part of the brain responsible for managing negative emotions is impaired, this part of the brain actually gets smaller.
What happens with memory during trauma?

• **Adaptive memory processing** is when what happens gets worked all the way though and stored into long term memory, or not.

• During **Traumatic memory processing** the memories get stored differently, likely due to increased activation at time of trauma.

• Traumatic memory doesn’t get processed through in the same way and the brain doesn’t know what to do with it so it gets encapsulated.

• Memories get stored in a way that whenever they come up, they feel like it’s now, unlike normal memories that become more distant as time passes.
Stimulus and response

Stimulus

Sensory Thalamus

Amygdala

Cortex

Hippocampus

Response

LeDoux, 1996
The stimulus response of traumatized brain

What does this mean?
The experience of trauma can compromise the individual’s functioning. Processing of information in the “rational” parts of the brain is impaired, and slower.

There are several studies that have repeatedly demonstrated the damage to the hippocampus and the cortex as a result of traumatic exposure. Impairment in neurological and cognitive functioning results.

LeDoux, 1996
COMMON REACTIONS TO TRAUMA

ANGER  CONFUSION  SADNESS  WORRY

NUMBNESS  FEAR

HURT  SHOCK  DISBELIEF  RAGE!  ANXIETY

MINIMIZATION

WITHDRAWAL  DENIAL

REVULSION  GUILT

GUILT

SHAME

BETRAYAL

DESPAIR

SELF- BLAME

PANIC

DOUBT

REVENGE!
What happens when a client with Trauma stops using drugs including alcohol?

• We have asked them to stop using their most effective way of dealing with their trauma
• Trigger city
• The very thing these people to make decisions is compromised
• Mixed gender in groups
• Social anxiety
• Institutional fear/colonization issues
• Numbing/shut down
Three phases of recovery

• Safety and Stabilization
• Remembrance and Mourning
• Reconnection and Integration

Dr. Judith Herman, *Trauma and Recovery*(1992)
Safety as a starting point for the work

• Therapists must create a safe, trigger free environment for the healing to even begin
• Creating and then holding a space for the healing to happen.
• Trauma work takes time.
Some of the do’s and don’ts

• Do position yourself in your office where the patient has the ability to leave without going through you.
• Do be prepared for traumatic material to come out during therapy.
• Do educate clients on trauma, how it works in the brain, and what to expect during therapy.
• Do give your clients permission to ask for help if they are overwhelmed.
• Do learn and use de-escalation techniques.
• Do learn clean, inviting language.
• Do not respond negatively or judgmentally to what you hear.
• Do not dismiss the relative pain someone is experiencing.
• Do not push the clients into working on things they don’t feel ready to work on.
Window of tolerance

• What we can effectively process in the now. When we can think and feel at the same time.
• Wise mind
Invitational language/Clean Language

• Invites choice instead of commanding:
  
  Example: Sit down on this couch/ I invite you to choose a place to sit.

• Attempts to keep therapists own biases out of the conversation:
  • Ex: That sounds horrible/How did that affect you?

• Looks for ways to empower client by using their own language and metaphor.

• Emphasize choice.

• Be curious, experiment.
Colonialization/Institutionalization issues

- Be aware that where you work, or who you represent, may be linked to someone’s trauma.
- Do what you can to minimize these, but you may not be able to.
- Sometimes acknowledging these things can help, but don’t assume.
Educate your clients about their nervous system

• Sympathetic and parasympathetic nervous system
• Poly vagal theory
• Activation
• Parts of brain involved in trauma
Trauma engaged SUD treatment

• Discerning the timing for working on the trauma
• Evaluating relapse risk
• Preparing clients for the process of healing from trauma
• Capitalizing on the skills we teach for relapse prevention