

Trauma and Substance Abuse: To Treat Separately or Together?

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Abstract

Trauma and alcohol or drug abuse has lifelong implications for trauma survivors and treatment of these issues is imperative. The question becomes though, what is the best form of treatment for these issues? The different types and forms of trauma are examined, as well as the possible links of how substance abuse and trauma become comorbid issues. Treatment types and modalities are also looked at and discussed. The Adlerian approach to treating trauma and substance abuse is also discussed as well as some Adlerian techniques that aid in treatment.

Keywords: trauma, addiction, substance abuse, co-morbid disorders, treatment

Trauma and Substance Abuse: To Treat Separately or Together?

Addiction or substance abuse to alcohol and other drugs is a monumental issue for many individuals to deal with, as there are many demons to face in chemical health treatment and recovery. The journey towards recovery gets even more complicated when an individual with an addiction or substance abuse issue is also suffers from trauma reactions such as Post Traumatic Stress Disorder, or Acute Stress Disorder. Trauma issues become and even more eye opening and tragic issues, when you consider that 5% of men and 10% of women in the US population as of 2009, have suffered some sort of trauma and will develop Posttraumatic Stress Disorder, (Mueser, Rosenberg, & Rosenberg, 2009). Women with substance abuse issues are at a particularly high risk for PTSD, as eight out of every ten women in a treatment program reports a history of sexual and/or physical assault or abuse, usually having happened in childhood (Hien, Cohen, Miele, Litt, & Capstick, 2004). Another study by Schiff, Levit, & Cohen-Moreno (2010), states that the co-occurrence of PTSD in substance-dependent women ranges from 30-59% in studies that have been conducted in the United States. For the mental health providers helping these individuals, treatment begins with the question of whether to treat the substance use issues first or the treat the trauma reactions first?

Which issue to treat first, or to treat the issues simultaneously can become a huge sticking point or hurdle for some patients and providers. Treatment of these two issues gets even more complicated when clients are also suffering from mental health issues. The most common mental health issues that occur co-morbidly alongside trauma and substance use issues are; depression, anxiety, eating disorders, and panic disorders, to name just a few, (Potter-Efron, R., 2006). So the question becomes for providers; what to treat and when? Do providers and or treatment centers address all the issues at the same time? Does the patient only deal with the addiction

issue first? Does he or she treat the trauma first? Do you deal with the other mental health issues first? The answers to these questions have changed over the past three decades and are still undergoing metamorphosis.

Why is more research needed in this area? For women who suffer trauma, in particular, researchers have found that these women have elevated rates of alcohol abuse/dependence when compared to women who use alcohol but have not suffered trauma, (Sator, McCutcheon, Pommer, Nelson, Ducan, Waldron, Bucholz, Madden, & Heath, 2010). Also, women who suffer trauma that victimizes in the way that sexual abuse, childhood sexual abuse and physical abuse do; are at more of a risk of suffering from trauma reactions, alcohol use and other comorbid disorders. These disorders can range from eating disorders, self mutilation, Borderline Personality Disorder, anxiety to depression (Potter-Efron, R., 2006). For this reason, the method or order of treatment for how to treat trauma and addiction issues needs to be dealt with.

This paper will first focus on the history of treatment of addiction and general trauma and how treatment of these issues has been treated up to the present day. The focus will then narrow to look at specifically how abuse, specifically; childhood physical abuse, childhood sexual abuse, and childhood and adult sexual assault affect an individual. The focus will then turn to how having co-morbid issues affect treatment and recovery, as sexual traumas and childhood abuses, seem to have the most far reaching and damaging effects, specifically on females. In fact, SAMHSA reported that “acts of interpersonal violence are so widespread across socioeconomic class and culture affiliation that some women consider it part of a “normative” female experience,” (Moses, Reed, Mazelis, & D'Ambrosio, 2003). Lastly, the discussion will lead to this paper addressing how issues of trauma need to be specifically addressed when women are in addiction and substance abuse treatment. The paper will conclude with a discussion of how

Adlerian techniques can be used to supplement some of the techniques already used to treat these comorbid issues.

Trauma

To start off, a definition of trauma is needed. Van Den Bosch, Verheul, Langeland, Van Den Brink, (2002), define trauma as, “Psychological injury resulting from an extraordinary stressful of life-threatening situation, accompanied by feelings of extreme helplessness and fear.” How individuals respond to the traumas that happen throughout their lives seems to be due to various factors. These factors include, coping ability, temperament, severity of trauma, if trauma reoccurs, and amount of control felt during the course of the trauma or abuse, (Jorden, 2006). Specifically, the severity of trauma(s), type of trauma(s), and number of traumas suffered come into play when treating these comorbid issues, because these issues are related to self esteem and self worth and how the victim sees him or herself in the world.

There are various traumas that can be suffered, from car accidents, to tsunamis, to assault, to sexual abuse, to the death of a parent, which can all befall an individual. These various types of traumas are divided into two types; controllable trauma and uncontrollable trauma. Controllable trauma involves an event where the victim is able to take some kind of action that influences the outcome of the incident, (Volpicelli, Blaraman, Hahn, Wallace, & Bux, 1999). The action over the event may be as simple of being able to try and fight the individual perpetrating the assault or finding a means of escape, or even getting to say good bye to a loved one. Uncontrollable trauma meanwhile leaves the victim feeling helpless and without any control over the outcome of the incident, (Volpicelli, et al., 1999). In these instances, the victims feel they didn’t put up a fight when they could have, or lost everything because a natural disaster wiped out their lives with a moment’s notice. Controllable versus uncontrollable trauma has a

huge influence on how victims deal with the trauma. Those individuals, who saw their trauma as controllable, tend to have better outcomes. Some sense of control over a situation allows for the victims to better integrate and process the trauma. The sense of control also allows for individuals to better grapple with the emotional wounds because, these individuals tend to believe that they did everything possible to defend themselves and survive the trauma or abuse.

Traumatic events can be further sub-divided into two types of events; short term, single exposure events and long-term, repeated exposure events. Events such as a car accident, an assault, a rape, a manmade disaster such as a school shooting, or even a natural disaster such as a hurricane, flood or tsunami, can all be classified as short term, single exposure trauma events, (Jorden, 2006). These events are defined as short term, single exposure events because they are events that tend to happen or be suffered only once. They are usually considered over in a matter of seconds to minutes. These short term single exposure events are usually much easier to treat for PTSD or trauma reactions, if they develop. Clients tend to feel like they experienced a sense of control over the situation and thus are less likely to question their self worth. Long-term, repeated exposure events are defined as war, child abuse, spousal abuse and child sexual abuse, (Jorden, 2006). With long term, repeated exposure events, there tends to be an ever present threat, that something could come and harm the individual no matter what the individual does to try to prevent it.

Long term, repeated exposure type of abuse seems to have the most lasting and vicious effects on individuals. An individual, who has suffered long term abuse, is more likely to be constantly on the defensive, looking for the next indication that an attack, assault, or beating is coming his or her way. This happens because the amygdala, on the brainstem, has adapted overtime, to respond to traumatic material for the sake of survival, (Goodman, Quas, & Ogle,

2009). Thus for the victims of abuse, their amygdalae have learned to respond to perceived threats at a heightened level. This heightened state of awareness of threats is the hyperarousal state. In this hyperarousal state, individuals over respond at the first hint of what they believe could be a traumatic experience (Goodman, Quas, & Ogle, 2009). Individuals who have suffered abuse have a quicker hyperarousal response than the rest of the population who has not suffered abuse or been exposed to trauma. For victims of abuse or repeated traumas, the hyperarousal state becomes a constant and a consistent part of the victim's life, causing the victim to feel entrapped in the situation, and thus the individual become conditioned to the abuse, (Courtois, 2008). The individual become so conditioned to what he or she is hearing, seeing and feeling from his or her abuser(s) that he or she begins to believe what the abuser(s) is/are saying.

Individuals suffering, or who have suffered physical and sexual abuse, in particular, are more at risk for developing trauma reactions because of the increased damage done to the ego and self esteem. Victims may be told that their behavior has brought about the abuse, or that they are extremely special, thus the reason for all the "extra special" attention. Also, threats from abusers, cause victims to self blame and worry about others in the family as the abuser(s) may threaten to hurt others in the family if anyone else finds out about the abuse. This kind of victim blaming is a form of emotional abuse, and it exacerbates the affects of the physical or sexual abuse that a victim is already be suffering, (Chang, Augenbraun, Ford, & Cruz St. Juste, 2008). This added emotional abuse, as well as the other forms of abuse suffered; create a cumulative effect on an individual which may cause them to suffer a trauma reaction. An individual may be able to handle one instance of abuse or trauma, but when or if it becomes cumulative, the trauma may exacerbate the coping abilities of the victim to the breaking point. The victim gets to the

point where he or she can't escape/forget about the abuse or trauma, since it is coming at him or her from so many different angles, at anytime possible.

All the elements of blame, shame and loss of control, related to physical and sexual traumas, cause many victims to internalize what they have heard. Victims may then start to blame themselves for the abuse, or see themselves as the problem. The abuse erodes any self esteem the individual has, and reinforces the false beliefs that tell the individual that he or she does not count, and is not important. Repeated traumas such as sexual and physical abuse teach the victim that he or she is an object to be used to fulfill others needs, (Nakken, 1988). It also teaches a victim that his or her own needs are not important, and therefore that the self doesn't count, (Nakken, 1988). Physical and sexual traumas also teach the abuse survivors on another level that, "people are objects to be used and manipulated for one's own benefit," and that "people are to be controlled," if they want to achieve any of their wants and needs, (Nakken, 1988). These are all elements of trauma that an individual suffers as part of physical and sexual abuse, and many times this leads to a decrease in an individual's self esteem, self-confidence and beliefs of self worth, (Courtois, 2008).

Sexual and physical abuse particularly, creates long term consequences that are many times not visible to the naked eye. Abuse especially, childhood abuse of that kind, disrupt the development of the self regulatory process. Individuals who've suffered repeated or very violent sexual and physical assaults, self esteem and self worth's are beaten to a pulp. This can lead to the individual beginning to hold the belief he or she is good at very little. Add to this that many times these individuals suffering repeated abuse, are not taught or exposed to healthy coping mechanisms. A defining characteristic of an individual who suffers from emotional deregulation is having lived in or living in an invalidating environment, (Linehan, 1993a). When these

situations combine it can lead to individuals having trouble responding in healthy ways to problems that pop up throughout life, with the appropriate reactions or emotions. Individuals with self regulatory problems are prone to have an emotional vulnerability and be more angry, hostile, irritable and anxiety at the flip of a switch, (Linehan, 1993b). These are the individuals who are also most likely to receive a Borderline Personality Disorder diagnosis. It has been speculated that the trauma caused by childhood abuse, specifically childhood sexual abuse puts these individuals at a much higher percentage for suffering from Borderline Personality disorder. Researchers' estimate that up to 75% of individuals with a Borderline Personality Disorder diagnosis have experiences some sort of sexual abuse in childhood, (Linehan, 1993a).

Attachment Formations

Trauma suffered because of sexual or physical abuse also affects an individual's ability to create healthy attachment relationships. Attachment is defined as, "the mental representations developed during infancy of the caretaker-child relationship that guide emotion regulation and interpretation of others' behaviors and intentions," (Goodman, Quas, & Ogle, 2009). Bowlby (1988), who developed attachment theory, also stated that attachment include the relational experiences as mentioned above, but is associated with human's basic needs for security. For physical and sexual abuse survivors, this basic need for security is key to how these individuals process the trauma(s). If as a child does not feel safe or secure, the internal working models of the self, in an individual will start a child questioning why he or she is not worthy of love, security or safety, (Bowlby, 1988). As a teen or adult these questions can turn to individuals using substances to feel loved, safe or secure.

It is posited that some people with attachment issues have suffered such severe abuse that it has affected their ability to trust others, and thus their ability to form healthy attachments

to others. As one individual who suffered trauma stated, “if the adults who were the closest to me could do something so damaging, then there was no reason to trust any adults at all, and certainly not the mental health professional who had the task of helping me...” (Cournos, 2002). These individuals, who’ve suffered trauma, in response, tend to then create either super close attachments or avoid all contact with others. Neither of these is healthy, as the super close relationships can become co-dependent relationships, and the avoidance of others can lead to issues with depression.

Attachment styles are usually representations of the attachment styles the individuals had with their primary caregiver in childhood. These four attachment patterns are defined as: secure attachment, avoidant attachment, and dismissing attachment, (Simpson & Rholes, 1998).

Individuals with secure attachments perceive others and themselves as positive and understanding and realize that there is a give and take to relationships, (Simpson & Rholes, 1998). These individuals usually had their needs met as a child by their parents when they were in distress. These individuals tend to have a sense of self worth and no issues with intimacy in a relationship, (Simpson & Rholes, 1998).

In the preoccupied attachment style individuals have a negative self view, but see others with a positive view, (Simpson & Rholes, 1998). These individuals usually feel worthless and seek approval from others. This attachment style usually produces co-dependent relationships, as the individual usually tends to cling to others to feel safe and secure and get his or her needs met. This attachment style typically comes from parents who only met a child’s needs when it was suitable for the parent. This is one of the most frequent attachment styles found in individuals who have suffered physical and sexual abuse in childhood.

With a dismissive attachment style, an individual sees him or herself in a positive view, sees others in a negative view, (Simpson & Rholes, 1998). These individuals are comfortable in their abilities, but do not let others in for fear of hurting being hurt or hurting others, (Simpson & Rholes, 1998). Parents in this attachment style typically did not respond to children's needs at all, or only when it benefits the adult's needs. The child thus learns that the only way to meet his or her needs is to do things by him or herself. This attachment style also is seen in cases of neglect and abuse.

In a fearful attachment style an individual sees self and others in a negative view, believing they have nothing good to offer, (Simpson & Rholes, 1998). These individuals are not good at screening the people they let into their lives and thus do not let anyone in close for fear of being hurt, but are highly dependent upon others for approval, (Simpson & Rholes, 1998). These individuals also tend to come from homes where they suffered abuse.

For individuals who have suffered trauma and develop substance abuse problems, one researcher found that some substance abusers formed attachments to their substances of choice that mirrored the attachment style they had with their primary caregiver during childhood, (Omaha, 2006). In other words, an individual only starts to use the drug of choice when he or she needs to feel escape or acceptance. . Van der Kolk (1989) states that children after abuse, maneuver to re-establish some sort of safety and stability and this involves turning in and blaming oneself for the abuse, instead of turning anger out on caregivers and losing the hope that parents or caregivers will not protect them. The individual then develops a relationship with the substance, and come to believe that the substance is the only item that can and will consistently meet his or her needs, when the individual feels hurt, lonely, scared or unloved.

Traumas Affect on the Individual

Individuals who suffer any types of trauma are at an elevated risk for not only Post Traumatic Stress Disorder, but, “depression, anxiety, self-hatred, dissociation, substance abuse, self-destructive and risk taking behaviors, re-victimization, problems with interpersonal and intimate relationship (including parenting), medical and somatic concerns and despair,” (Courtois, 2008). While these are some of the side effects of trauma and abuse, there are ways that traumas affect the body. Many events of everyday life are experienced through the bodily sensations, from the heat of the sun to the touch of a loved one, to the sound of a TV or the brightness of a light in a room. For trauma victims who develop trauma reactions such as PTSD, the sensations experienced during a trauma can be re-experienced again and again, with or without a trigger, as nightmares, hallucinations and flashbacks,(van der Kolk, 1989).

Another way trauma affects the body is that the trauma of an event can come out as physical symptoms. The body of a victim typically begins to express physical symptoms, with no apparent cause. This can happen because the individual is choosing not able to verbalize and deal with the traumatic memories because of the shame or fear that was involved with the traumatization, or because the victim has suppressed it, choosing to pretend it never happened (Moses, Reed, Mazelis, & D'Ambrosio, 2003). Other times, a victim may not realize how traumatic an incident really was and just go on with his or her daily life until trauma reactions start to appear. Some of the physical symptoms that are suffered by victims of abuse can be; chronic pain, gynecological difficulties (especially pelvic), gastrointestinal issues, asthma, heart palpitations, headaches and musculoskeletal difficulties, (Moses, et al., 2003). When individuals go to doctors about these symptoms, they are many times told the symptoms are in their heads or they are misdiagnosed. This happens because the either doctors don't ask about abuse or trauma

histories or the individual does not disclose that he or she has suffered trauma. This adds to the trauma already suffered because then individuals start questioning their own feelings and experiences. Usually these symptoms are experienced in relation to where the abuse was perpetrated upon the individual, since “the body remembers what the mind forgets,” (Dayton, 2000). Humans remember not only in the mind, but also in the muscles of the body. “Muscles remember the muscular tension, holding, tingling, warmth and incipient movements of past traumas and will signal pain or danger even if the individual is not in a dangerous situation,” (Dayton, 2000). These symptoms if not treated can have lifelong consequences. From increased risk for heart attack and stroke because of stress, to heightened risk for suicide, these individuals suffer the consequences of trauma physically as well as psychologically. These individuals can also lose out on new experiences and relationships because of the trauma reactions. In some instances, individuals may even put themselves in other dangerous situations that could put them at a higher risk for more trauma and re-victimization.

Trauma reenactment is another way trauma can affect clients, sometimes in ways they may not even realize. Trauma reenactment occurs throughout society but is given other names because many times survivors of trauma do not share their trauma experiences with others out of shame. Thus, as a society we have labeled these clients instead, as self harming, aggressive, and criminal. When in actuality these trauma survivors are communicating their stories to other via internalizing or externalizing behaviors, (Chang, Augenbraun, Ford, & Cruz St. Juste, 2008). The client who always seems to self harm at the same time every night, or a client who is suicidal at the same time every year, or a client who steals items of no significance are all behaviors that are trauma reenactments. Through these behaviors clients are trying to get their stories acknowledged without actually dealing with or admitting to suffering trauma. In some

way, these clients are hoping that their behaviors will prompt someone to ask about the trauma(s) they suffered during childhood so that they can finally break free of it. Many times clients don't even realize the significance of these behaviors, since the behaviors are the individuals coping mechanisms. Many times individuals don't deal with the behaviors or the memories until they are forced into therapy, whether by family or by the criminal justice system.

Trauma experiences have life-long implications on how an individual functions and develop as a person. This is especially apparent when looking at women who are suffering from Posttraumatic Stress Disorder or other trauma reactions as the result of a traumatic experience. Typical symptoms of trauma reactions, such as PTSD, that trauma survivors must deal with are divided in three categories; persistent re-experiencing of symptoms, persistent avoidance of symptoms and emotions, numbing of symptoms, and persistent hyper-arousal, (Hambley & Pepper, 2010). Intrusion symptoms are classified as persistent, re-experiencing symptoms. They can include symptoms such as flashbacks and nightmares, (Hambley & Pepper, 2010). Avoidance symptoms, on the other hand, can include not wanting to talk about the event or avoiding the place where the trauma or abuse happened, (Hambley & Pepper, 2010). Numbing of symptoms is attained through chemical use or self harm. Hyper-arousal symptoms can include a heightened startle reflex and hypervigilance, that feeling of always needing to be on guard, (Hambley & Pepper, 2010). All these symptoms start to take their toll on the individuals, because an individual's life starts to revolve around the symptoms of PTSD and trying to avoid them and or control them. Methods of avoiding these symptoms can include alcohol and drug abuse, self harm such as cutting, development of an eating disorder and isolation to name a few.

Substance Use and Its Role in Trauma

Substance abuse problems result many times when an individual has suffered sexual trauma. In fact “Malinosky-Rummell and Hansen,(1993) found that in four out of five controlled studies,” individuals with substance abuse issues were more likely to have histories of childhood physical abuse, and the same was found true for individuals who have suffered childhood sexual abuse, (Clark & Foy, 2000). Bradly et al. (2004) found that those individuals with the most severe substance abuse problems were also the individuals who had suffered the most severe physical and sexual victimizations and were the most likely have suffered multiple traumas, (Clark & Foy, 2000). In particular, a study by Kilpatrick et al., (1994), found that women with histories of parental substance abuse or physical or sexual victimization were 2.3-3.5 times more likely to abuse substances, than those with other types of trauma issues (Clark & Foy, 2000). Females, who fall into all these statistics, have the cards stacked against them and have the highest odds of suffering severe substance abuse and/or addiction.

Substance abuse and/or addiction issues develop for women with trauma histories, with one step. These women begin using alcohol and other drugs to bring about sleep, or just a feeling of nothingness. They drink or use substances as a way to deal with the nightmares, flashbacks, and hypervigilance feelings related to the abuse they’ve suffered. From this viewpoint, it can be understood then how women develop substance abuse and addiction problems as they find that the substances are the only things that make them feel okay. They then start using alcohol and or drugs more often and increasing quantities to get the desired effect, of feeling nothingness.

Substance abuse disorder includes symptoms such as; unsuccessful efforts to cut down on substance abuse, taking the substance in larger amounts or over longer periods of time than intended and recurrent substance abuse in situations that are physically hazardous to the

individuals safety and health, (Najavits, 2004). Addiction is meanwhile defined as a, “compulsive need for and use of a habit-forming substance (characterized by tolerance and by well-defined physiological symptoms upon withdrawal; or a persistent compulsive use of a substance known by the user to be harmful” (<http://www.merriam-webster.com/dictionary/addiction>, 3/13/11) or “a physical or mental dependence on a behavior or substance that a person feels powerless to stop,” (<http://www.healthline.com/galecontent/addiction#ixzz1GUqLcjXk> , 3-13-11). These definitions while similar also delineate a delicate line that explains when use of alcohol and other drug use goes from being used as a coping mechanism, to being just craved after and needed to feel normal.

The definitions of substance abuse and addiction, while helpful in defining a problem, are not important in the actual psychological treatment of an individual with an alcohol or drug disorder. The definitions do though help to inform staff about the individual when he or she comes into treatment. Delineating between abuse and dependence informs therapists if a client is going to go through withdrawal, and what the possible severity of withdrawal the client is suffering. This is helpful to know when treating clients because those clients, going through withdrawal are going to focus more on their physical symptoms of discomfort, instead of the curriculum being taught to them regarding recovery. It is important to realize this, since clients in treatment will need to learn new coping mechanisms. These new coping mechanisms may need to be taught to clients multiple times during treatment since they may not remember the first few times, as their brains come out of the fog created by alcohol and drug use. It is especially important to teach those suffering trauma issues coping mechanisms at this juncture, otherwise the trauma reactions will interfere with the substance abuse and addiction treatment.

Typologies of Trauma and Substance Abuse

There are different types of comorbid manifestations of alcohol use and trauma, in regards to type and severity. Typically, trauma reactions and substance use are subdivided into three categories. The first category is the one most often seen in inpatient and outpatient treatment programs. In this category an individual is seen as having an active addiction that presents clearly with all the typical symptoms, (Steele, 2000). These symptoms include, increasing levels of use and tolerance, true withdrawal symptoms and actual negative consequences to drinking, (Steele, 2000). Clients at this stage typically will not disclose information about any trauma experiences and are likely to laugh off or dismiss any serious negative consequences to such trauma experiences and likely have no repressed memories, (Steele, 2000).

The next typology of co-morbid trauma and substance abuse contains individuals who have active addiction and active trauma issues. These individuals are most likely to be seen in inpatient care as they use in increasing levels to block the symptoms of trauma, and thus are more likely to have more active addiction issues. These individuals usually experience the same symptoms as the previous group in regards to substance abuse, with the increasing levels of use and tolerance. These individuals are generally more likely to complain of somatic issues; such as depression, anxiety and other symptoms that are typically classified as trauma related, such as hyper-arousal and nightmares, (Steele, 2000). These individuals are also less likely to connect the dots and realize that his or her use of alcohol or other substances is his or her method of coping with the stress of trauma issues.

The last classification group is those individuals who have active trauma issues but only reactive chemical use. These individuals are the most likely to be seen by a private therapist

because their substance use is not on a noticeable or problematic level yet. These individuals typically have none of the negative consequences related to drinking. No withdrawal symptoms and no change in tolerance levels, but these individuals typically will report an increase in use over time, in response to trigger issues, (Steele, 2000). Trigger issues are usually related to trauma experiences. This type of client is one where a therapist may not know the individual has any substance problems, until something triggers the client and reminds him or her of the trauma he or she has suffered and the individual goes to using substances as a way of coping with the traumatic symptoms. These individuals typically are able to go back to not using a substance, or using with moderate use at regular intervals after this, unless triggered by trauma symptoms.

Comorbidity Causation Theories

Before going into treatment modalities, there is a need to look at some of the models that explain why alcohol and other drug abuse issues and trauma seem to be co-morbid problems. There seem to be multiple possibilities for explanations of what causes these issues of substance abuse and trauma to occur co-morbidly together. Some of the reasons are singular, stand alone explanations, while others build upon previous theories. One model discussed by multiple researchers posits that alcohol and other drugs are used as coping mechanisms or a form of escape by trauma survivors. This theory is labeled as the Self-Medication Hypothesis of Addiction. In this hypothesis, substances are used by clients as a way to reduce negative emotions associated with childhood and adult traumas, and or as a way of easing the painful emotions or physical symptoms that are resulting from PTSD, (Schiff, Levit & Cohen-Moreno, 2010; Hien, Campbell, Ruglass, Hu & Kileen 2005). The use of drugs or alcohol allow for a victim to depress the systems in his or her body. This depression of bodily functions allows individuals to not experience feelings of constant fear, pain or shame. This model has been

found to be consistent with research findings that suggest that exposure to childhood trauma disrupts the self-regulatory process, thus leading to long term problems in with emotional self regulation, (Hein, Cohen & Campbell, 2005).

Another theory discussed by researchers posits that drug use provides a sense of control for an individual. It has been hypothesized that in the beginning for many individuals, drug or alcohol use allows an individual to feel like he or she has gained control over the trauma reactions. As Nakken, (1988), puts it, "Control, is part of the attractiveness of an addictive lifestyle, it has one believing he or she has control over his or her world. Ironically it's the addicts search for control that causes him or her to have less of it." One of the key elements of having suffered trauma is that the individual feels feelings of extreme helplessness and fear. For many people feelings of helplessness denotes a loss of control. Many individuals, who experience trauma, experience this sense of loss of control and search for ways of reestablishing control in their lives. For example, if an individual is not able to control simple things in his or her life such as what he or she eats, or who has access to his or her body, the individual will search for small ways of having control. For someone who has suffered trauma, drinking may start out as the one way the individual has control over how he or she feels. When he or she drinks, the individual feels nothing and experiences nothing. Other ways of establishing a sense of control have been the development of eating disorders, cutting, exercise addictions and other such behaviors.

Another theory floated around, is the Endorphin Deficit Model. This model hypothesizes that when a trauma happens, the endorphin levels in the brain shoots up in response to the trauma that is being experienced. The endorphin levels shoot up so that all systems in the body are ready to fight if need be or flee, as this is the evolutionary fight or flight response activating.

Women with a history of childhood abuse, in particular, have been found to exhibit an increased response to adrenocorticotropin (an endorphin) when in physiological stress, by nearly six times from those in the control group who had suffered no abuse, (Schoedl, Costa, Mari, Mello, Tyrka, Carpenter & Price, 2010). Therefore women's brains, who've suffered trauma, are always triggering warnings to let them know they are in trouble. These women are constantly then on guard to abuse or harm, since their bodies are always signaling danger is around the next corner. The increase in adrenocorticotropin thus puts these women at more of a risk to develop depression (Schoedl et al., 2010). Between the trauma reactions and feelings of depression, these women suffer constant feeling of anxiety, which can be draining. The women may then use alcohol or other drugs to numb these feelings, like the self medication theory hypothesizes.

It has also been proposed with this model that individuals who suffer an uncontrollable trauma have an increase in the amount of endogenous opioids that are released during a trauma incident, which help numb the pain of a trauma while it is being experienced, (Volpicelli, et al., 1999). When these endorphins start to decrease, the individual will exhibit the emotional distress that is typical after a traumatic event. The endorphin withdrawal may also bring about an increased desire to drink alcohol as a way to compensate for the endorphin deficiency, (Volpicelli, et al., 1999). This happens because alcohol mimics the endorphins in the brain and keep the endorphin levels from dropping, thus delaying the emotional distress typical after a traumatic incident. Thus, an alcohol addiction may develop over the course of time, as an individual drinks more and more often and in larger amounts, to prevent the feelings of emotional distress that precipitate the endorphin withdrawal.

Another theory also suggests that these women have suffered such extreme abuse that they use drugs as a way to allow them the ability to re-experience the trauma believing on some

level that re-experiencing the trauma will allow them to react differently to the abuse and create a different outcome. During this re-experiencing of trauma, victims of abuse may play the role of victim or victimizer. Women in an effort to re-experience trauma may become prostitutes, pose for pornography or allow themselves to be assaulted again by someone who mimics their original abuser, (van der Kolk, 1989).

The last model is the abuse-addiction model claims that since abuse and traumatic experiences are all that a client knows it is the only way the individual knows to function and feel normal, especially when the abuse happens in childhood, (van der Kolk, 1989). Alcohol or drug abuse starts as a form of escapism, but continues, since it creates the same feelings of abuse and shame the individual experienced while being traumatized. Since these feelings are all that a victim knows and experiences as normal, they do whatever is necessary to achieve this sense of normalcy. For these individuals the only way to feel normal is to self abuse/ self traumatize.

The last theory is called the High Risk Hypothesis. This theory suggests that an individual may start to drink as a coping mechanism to deal with a first instance of trauma,. This drinking thus puts the individual in unsafe situations, and heightens his or her risk of re-victimization, (Najdowski & Ullman, 2009). If an individual is victimized again, be it by the same victimizer or new perpetrators, he or she will drink again to deal with a second occurrence of trauma, since that's how the individual learned to cope with the first traumatic incident. Thus starts a vicious cycle of substance abuse and PTSD symptoms. In fact a study by Wilson, Calhoun and Bernat (1999) found that the numbing symptoms decreased the ability of sexually victimized women to recognize risk, in a scenario depicting rape. Thus these women when drinking were at additional risk to get themselves into dangerous situations again. These women were more likely to be targeted by perpetrators who may have viewed them as vulnerable, and

were less able to resist the unwanted sexual advances of another individual, thus increasing their likelihood of experiencing another trauma, (Najdowski, & Ullman, 2009).

Modes of Treatment

Treatment in the past and now has been is delivered in three different manners; parallel, sequential and integrated. Each of these modes has been predominant at one time or another, but all three are still used today. In parallel paradigm of delivery, clients receive treatment for addiction issues in group or program and then receive treatment for psychiatric disorders and or trauma related issues in another program or group, (O'Donnell, & Cook, 2006). This can obviously lead to fractured and fragmented treatment, where clients may get differing or opposing messages about treatment and recovery. Programs for recovery may promote giving up control to a higher power in order to overcome a substance abuse issue, while a program treating trauma reactions would work with clients on learning to control, only what they can control. This parallel treatment set up can also create more barriers for clients to navigate through and create feelings of failure because a client can't get through the barriers. These barriers can include issues with the scheduling of treatment, the advice given in groups, and how treatment programs are paid for, to name just a few.

Treatment with a sequential setup usually, first focuses on addiction and/or substance abuse issues and the need to abstain from substance use. The client will follow substance abuse treatment up with a program that looks at and deals with the trauma issues and teaches clients how to deal with their trauma distress. This type of program set-up puts clients in a bind many times as there their symptoms and problems related to comorbid substance abuse and trauma issues are not addressed, or are under addressed in each program. This happens when each program assumes the other programs clients are doing has taught clients the needed skill sets.

When this happens clients enter into that toxic cycle of treatment and relapse because they still haven't been taught or learned new ways of coping to deal with the issues that both problems. This type of set up was more popular in the early years of treatment programs because of fears about opening Pandora's Box when dealing with trauma issues in substance abuse treatment. Providers were afraid that treating trauma during substance abuse treatment would lead to clients having huge trauma reactions that were worse than in the past, with no ways to cope with the reactions, (O'Donnell, & Cook, 2006).

The integrated model of treatment involves treating both issues at the same time, in a simultaneously coordinated way. This overlap in some areas also allows clients to gain new insight and knowledge about each issue. Clients in this model of treatment are able to get questions answered about both issues with one response. It is with this integrated model that we see more of the specific and holistic modes of treatment that look at the complete person being treated. With this kind of view issues from housing, health, nutrition, economics, mistaken ideals, race, sex, and coping mechanisms are all discussed in regards to how they play into a clients problems and to how a client can deal and cope with all these issues in a positive way in the future (O'Donnell, & Cook, 2006). This model of treatment typically links clients with resources they need in the community, while the previous two models typically leave the client to find and connect with the needed resources. This model seems to be gaining traction in the last few years as more empirical support comes to support its use.

Treatment History

Why has an integrated model not been used to deal with these comorbid issues and treated them at the same time in the past? The first reason lies with the fact that, until the 1950's addiction was looked as a failing of moral character. Society saw addicts as low-life's who were

unmotivated and who had low and lapsed moral codes. Many in society believed that individuals suffering addiction and abuse problems could stop use of a substance if he or she really wanted too. The mid 1950's to early 1960's brought about a model that looked at addiction as an underlying psychological disorder. With this model there was a belief that if an individual could solve the underlying disorder causing the addiction, then the addiction would just go away by itself and a person could go back to moderate use of the substance (Covington, 2000). This idea is still believed by some substance users. These individuals believe if they stay sober for a few weeks, months, or even years that they have beaten their abuse and addiction issues and that they can go back to moderate use after awhile.

It was also during this same time that the chemical dependency field as it is known today was born. Alcoholics Anonymous and the 12-Step movement really started to take hold at this time and helped to promote another model of addiction that saw addiction as a physical disease, a primary condition with its own symptoms that needed to be treated as such (Covington, 2000). This idea that addiction is like diabetes, or heart disease, a condition that needed to be managed with lifestyle change and willpower was a game changer because it took away the moral stigma. It allowed those not dealing with addiction issues to see that people couldn't just stop an addiction or substance abuse problem and that these individuals needed help to change their lifestyles. It was one of the first time society looked at the true reasons for why individuals were drinking without trying to make it into a moral or test of wills issue.

The original solution for many suffering from addiction is abstinence. This is the idea that an individual remain sober from all drugs and mood altering substances. Abstinence is defined as the "forbearance from any indulgence of appetite," (<http://www.merriam-webster.com/dictionary/abstinence>, retrieved 4/5/11). The idea of focus on total sobriety is great

when it's the only issue that a client is dealing with. But the reality is that most individuals aren't just dealing with substance abuse and addiction issues. Those using mind altering chemicals are usually are using substances to avoid other issues. The problem with a the original idea of focusing on just abstinence in treatment was that providers believed that just treating the addiction and substance abuse symptoms, would allow individuals to start to feel better and healthier. This healthier state and outlook was believed would allow clients to be better able to begin again the life tasks of creating a manageable life, free of alcohol (Miller, 2002). The focus on just the physical aspects of addiction and substance abuse issues itself ignores the reasons feeding the addiction. This creates problems for those especially with comorbid trauma and addiction issues. Many of the individuals are in treatment because they've used substances to cope with the after affects of the trauma. Then when these clients are in treatment they are forced to be without the substances, and are given no new tools to deal with the trauma. Clients then go back to what works for dealing with the trauma...alcohol or other drugs. Thus this revolving cycle of substance abuse to deal with trauma if the trauma aspect feeding the addiction is not dealt with right away in treatment.

Up until the 1980's, for those individuals with trauma issues, if trauma issues were triggered in a treatment setting clients were told that drug and alcohol treatment was not the time or place to bring up the issues. Thus, making a client feel more shame and anger for having a trauma reaction, he or she cannot control, and attacking a individuals sense of self worth even more. Providers gave clients this kind of response for multiple reasons. Many providers when treatment centers were just getting started did not know or understand how to react to, or deal with trauma reactions. Many also believed that clients were not yet strong enough to deal with the trauma issues, and that to deal with it during addiction treatment, would cause an individual

to relapse. These individuals were put through treatment and given great information about how to stay sober, but not given information about how to deal with the trauma or cope with the symptoms related to their substance use. Many individuals were told that they needed to deal with the addiction and substance abuse issues first because these were more pressing issues. Individuals were told that once they were sober, they would then be “healthy” enough to deal with the trauma issues. The problem with this line of thought is that the trauma reactions for many of these individuals are the trigger that then leads to relapse (O'Donnell, & Cook, 2006). As Miller (2002) states, “Addictions, mental health problems, and trauma seem to form a toxic feedback loop: the mental health symptoms caused by trauma related distress continuously stimulate the addiction compulsion and the addictive behaviors the generate distress of mind, body and spirit.” What client is going to choose sustained abstinence when he or she is dealing with flashbacks, feelings of depression, and other such symptoms as well as the stresses of everyday life, if he or she has only learned about addiction issues and not how to cope? When thought of in this way, it makes sense why this particular population of clients has higher relapse rates. As practitioners, this line of thinking helps in understanding why both of these issues need to be dealt with simultaneously in a treatment.

Since the early nineties the shift has been to treat individuals from a more holistic viewpoint. This has included learning to treat addiction and trauma at the same time in one program. A holistic viewpoint of treatment allows providers to focus on treating an addiction as a primary problem, while still addressing the other dimensions of addiction as a disease such as, “genetic predisposition, health consequences , shame isolation and/or a history of abuse,” (Covington, 2000). This holistic viewpoint also allows providers to address societal issues such as gender and sex roles and how these affects addiction and trauma manifestations, especially for

females. By using a holistic viewpoint to treat addiction and trauma patients can address misconceptions that may have fueled their addiction and trauma. This holistic treatment approach also allows clients to connect to outside resources and get issues such as child care, employment, housing and schooling taken care of.

The move to holistic treatment has also created treatment programs that are trauma focused/specific and trauma informed. Trauma informed has come to mean that treatment programs “possess an understanding of trauma, its impacts, consequences and pathways to healing at all levels of service,” for the clients these programs are serving (Chang, Augenbraun, Ford, & Cruz St. Juste, 2008). This is important for clients receiving treatment. It means that women receiving trauma informed services will be working with individuals who have knowledge of what the women are experiencing. Thus female clients receive affirming response of what they are feelings and experiencing and are therefore more likely to build up self image self esteem and feelings of self worth. These clients will also get providers who emphasize strengths, work with women on collaborative level instead of a teacher student level, and respect the control and choices that the women execute over their lives (Moses et al., 2003). These are all huge issues for women who have suffered specifically physical and sexual trauma in childhood, since many times these are factors that the women have had little control over in their lives. For many of the women, the respect and affirmations received during trauma informed programs are the first time in a long while that these women have been treated as worthwhile individuals. To accept these affirmations as true takes much work on the part of the patients. These women literally need to relearn from the beginning how to cope and interact with others.

Treatments

Trauma focused/specific programs are programs that are typically defined as having: “Interventions designed to address the specific behavioral, intrapsychic, and interpersonal consequences of exposure to sexual, physical and prolonged emotional abuse,” (Moses et al., 2003). These are the programs usually seen as types of therapy that help to deal with the specific behaviors related to addiction and trauma issues. These programs typically have interventions specifically aimed at those with a comorbid diagnosis, as part of treatment. Interventions in these programs can be therapies such as EMDR, DBT and trauma groups.

Cognitive behavioral therapies. Cognitive behavioral therapies are the most employed treatments with individuals with comorbid substance abuse and trauma issues. These therapies tend to be the most used with clients for a number of reasons. The first being, many of these cognitive behavioral therapies have been validated time and again, with multiple studies and are proven the best for use with clients. The second reason is that these therapies are multi-dimensional and work on more than one area of the body. What’s meant by this is that these therapies tend to work on thought patterns or beliefs while also working with the behaviors a person exhibits. These interventions help the individual to change and reinforce positive beliefs and thought patterns, while extinguishing negative ones. The therapies also tend to examine the emotions that individuals exhibit, as well as the intensity of these emotions and the physiological presentation of these emotions and thoughts. Interventions that come from a cognitive behavioral background also examine how all these components work together in a client and how all these components are expressed in a client’s issues. Cognitive behavioral therapies work with individuals with substance abuse issues and trauma reactions because the cognitive behavioral therapies are based on the premise that problems and problem behavior or harmful coping

mechanisms are the, “result of maladaptive or distorted thinking, which effects both emotion and/or behavior,” (O'Donnell, & Cook, 2006). “In turn, these emotions and/or behaviors reciprocally and cyclically affect thoughts which are reflective of the distorted beliefs clients hold regarding self, world and others,” (O'Donnell, & Cook, 2006).

One way cognitive behavioral therapies work is through the use of classical conditioning. Think Pavlov's dog, and cuing individuals to do or not do something through reward or punishment. Clients learn new behaviors and extinguish old ones through repetition, positive reinforcement (being rewarded when you answer a question correctly) and negative reinforcement (being forced to do something you hate everytime you make a certain mistake). An example of classical conditioning with a client would be working with a client to making a list of ideas a client can do anytime he or she starts to feel a trauma reaction coming on. To get the client to do an item on this list anytime a trauma reaction starts to come on, the client could be promised a reward. If the client instead returns to an old coping mechanism, such as cutting or drinking, the negative reinforcement could be added homework. This serves the dual purpose of creating a new pattern in the brain that rewards the client and it helps to extinguish the old pattern the client would have of self-sabotage any time he or she started to have a trauma reaction.

A cognitive behavioral technique that is used specifically for the trauma aspects of working with a client includes doing some sort of exposure therapy. Exposure therapy seems to work well with lessening or extinguishing trauma reactions. It allows a client to confront a traumatic memory with the knowledge that has been gained since the original incident and change how the client feels or reacts to the traumatic incident. Doing in-vivo or imaginal therapy like this with a client is invaluable if the client can handle going back to the memory because it

allows the client to feel a sense of control over the abuse or victimization that happened in the original traumatic incident. This sense of control is huge with trauma victims as it is an important factor in how the person understands the event, his or her role in the event, and how an individual sees him or herself in relation to his or her abilities, (Volpicelli, Blaraman, Hahn, Wallace & Bux, 1999). While doing the imaginal and in-vivo therapy a client can go back and change small things in the way he or she remembers the event to create a better sense of control in the memory.

Eye movement desensitization and reprocessing (EMDR). Another type of treatment that is used specifically in the treatment of trauma is Eye Movement Desensitization and Reprocessing. The purpose of EMDR with trauma clients is to “identify and process the experiential contributors of dysfunction and health,” that stem from a trauma event, (Zweben, & Yeary, 2006). The emotions and sensations that clients are dealing with post trauma are thought to be the feelings, sights, sounds and smells from the trauma event that have gone unprocessed. When trauma is unprocessed it can cause patients to feel like the past is the present, (within and outside of the body) and thus creating the pathology that client are dealing with. According to the Adaptive Processing Model which guides EMDR practice, what happens during a trauma is that the body is under intense stress and this causes the processing system in the brain to function improperly. Essentially the processing system in the brain overloads and stops processing the information from the experience. This leaves the disturbing images, feelings, smells and emotions experienced during the trauma stuck in the memory network. These memories are then unable to link or find any more adaptive memories that may help the individual process the event and integrate the experience into his or her being, (Zweben & Yeary, 2006).

EMDR is one type of intervention used in cognitive behavioral therapy that requires the client go back and deal with the past. But it does not require that the client disclose a full narrative of the traumatic event to a therapist to be treated. EMDR was conceptualized as, “An information processing model of trauma resolution, in which the standardized procedures and bilateral brain stimulation facilitates entry into an accelerated learning state in which traumatic experiences can be processed effectively and efficiently” (Zweben, & Yeary, 2006). In other words, the bilateral brain stimulation brought about through tapping or eye movements allow a client to go back and deal with problematic memories in a way where the client is in control instead of being the victim.

Patients are trained before doing this therapy, to self soothe and find ways to reduce distress so that recalling the event does not cause more or worse trauma reactions within the client. Once a client is able to reduce distress and self soothe with less potent memories, the client works with a therapist on recalling the memory of the traumatic event(s) and any associated features. Associated features of trauma are things such as negative self-statements or negative beliefs about people or the world (Rachamin, Nacasch, Shafran, Tzur, & Gilboa-Schechtman, 2009). At this point, lateral sets of eye movements, taps or tones are infused simultaneously with the traumatic recall of the event, and this creates bilateral brain stimulation. Bilateral brain stimulation helps in allowing a client to process the event, his or her feelings and emotions that went with the event (Zweben, & Yeary, 2006). After finishing EMDR treatments, clients typically report reduced trauma reactions or no trauma related reactions

Dialectical behavior therapy (DBT). One program used with clients in substance abuse treatment and trauma for clients with comorbid substance abuse and trauma issues is Dialectical Behavior Therapy (DBT). Dialectical Behavior Therapy was originally developed for use with

individuals with Borderline Personality Disorder, who have problems with emotional regulation. Individuals with addiction and trauma issues usually suffer from issues related to emotional regulation alone. They differ from individuals with Borderline Personality Disorder diagnosis in that these individuals tend to try to deny or ignore emotions until the emotions become too much to cope with. These individuals also tend to make dramatic gestures for attention and usually have issues with suicidal ideation. The program is composed of both individual and group meetings to work on issues. The program works on issues of distress tolerance, mindfulness, emotion regulation and interpersonal effectiveness. Clients work on these areas by leaning each issue in a skills session and then practice the skills in real life and through role-play with group members and the therapist, in group. Clients also meet individual with a therapist to discuss use of skills in the client's daily life and any issues that may have resulted as a use of these skills. DBT is helpful in getting client to learn to accept themselves and the world as it is in that moment (Linehan, 1993).

The DBT skills of distress tolerance and mindfulness are particularly useful with clients with substance abuse and trauma issues because of these clients' deficits in behavioral coping skills. These skills work on items as simple as teaching the value of emotions to clients; in that emotions are motivators self-validating and influential in our interactions with others, (Linehan, 1993). This is useful for individuals in treatment for substance abuse and trauma because these clients usually have had minimal learning of lessons about self-care, health coping, negation, and even what is health emotional expression. This happened because of members of their families of origin didn't have these skills, or as a result of the trauma, clients belief structures changed. Changes in belief structures because of trauma, especially when the trauma has been perpetrated

by another person, are usually related to thoughts about self-esteem, ability, trust of others, and dependability on other versus self.

Another skill set that is especially helpful for these individuals to learn are mindfulness skills. With these skills a client works on learning that he or she can control what he or she feels like. For many clients this especially means learning that if they feel a certain way such as hurt or angry, they can't control how another person they are interacting with will react to them, or what is going on in their environment. This skill is particularly helpful for those with abuse histories because it puts the locus of control back in the client's court. It also means taking in and experiencing emotions and feeling for that they are without judgment.

Treatment Programs

Many of the treatment models that have been developed to work with clients with comorbid issues are models that use some aspects of the cognitive behavioral therapies discussed above. One of these, Seeking Safety, is a therapy that focuses on the present and what clients can do now to deal with the trauma and chemical use issues and develop new ways of coping. This program has twenty-five treatment topics that are discussed throughout the program. These topics cover themes from four content areas; cognitive, behavioral, interpersonal, and case management and the promotion of safety and recovery. These content areas cover topics ranging from self-care, community resources, coping with triggers, healthy relationships, and boundaries to name just a few. As well as discussing eighty different safe coping skills that promote safety for oneself, and an abstinence free recovery (Najavitis, 2002). These are all items that are great for discussion and treatment with this population because so many patients, who come in for substance abuse treatment who have trauma issues, have never looked at how to care for themselves and their in relationships with lovers, family and friends. Many patients when they

first enter treatment are in a fight or flight mode, and were all the time previous to coming into treatment. Many clients don't realize it, since they were doing what they thought they needed to do to survive in life. For many this meant putting others needs ahead of themselves, and thus putting themselves in situations where they were used again and again. Original traumas are thus reenacted again and again then for clients, because they aren't dealing with the issues. Integrated programs such as Seeking Safety, may be the first time that some of these clients learn what a healthy relationship looks like, or how to set up boundaries and how to deal with others if the boundaries are crossed. Numerous studies have found that the Seeking Safety program creates, "significant improvements in substance use, trauma-related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, cognitions about substance use and didactic knowledge related to treatment" (Moses et al., 2003).

Another program that is commonly used in treatment for dual diagnosis of substance abuse and trauma is Addictions and Trauma Recovery Integrated Method, or better known as ATRIUM. This program works through "psychoeducational, process and expressive activities to help women recontextualize their experiences and adaptive strategies" (Moses et al., 2003). The program is a group program made up of four sections, to be used over twelve weeks. The first section looked at in this group is The Theory of Trauma Reenactment. This section looks at how traumatic stress plays a role in addiction and mental health issues, both individual and on a systemic level and globally. This section is great at creating connecting dots for patients to see how in their own lives mental health issues and trauma have played out. The second section examines The Impact of Trauma Reenactment on the Mind, which goes into how addictions are present in all the major mental health conditions such as; "depression and grief, anger, fear and anxiety," (Moses et al., 2003). In other words this section focuses on having clients describe and

discuss how these issues play off one another and feed their issues. The third section is The Impact of Trauma Reenactment on the body. This section examines how trauma reenactment is expressed throughout the body in somatic ways. It also examines as well, how trauma affects the way women view their bodies and how women experience intimacy and touch as a result of their traumas. This information is especially relevant for women who have suffered physical or sexual traumas, since they are the most likely to associate any kind of touch on their bodies as tied to being hurt. The information is usually eye opening for many of the women in treatment because they've never realized how one event or a repeated abuse could affect so much of their present lives. Many times clients are head to say "I thought I had moved past the event and dealt with it" when in reality moving past an event meant burying the event and any feelings associated with it, thus not dealing with the trauma. This section can also be reaffirming for many women. It allows them to realize that the alcohol and drug use were their ways of self-medicating some of these issues. The last section is useful for women towards the end of treatment since it helps them to build bridges with family, friends and other supports. It examines The Impact of Trauma on the Spirit. This section explains to women how spiritual well being is understood as being in relationships with friends, partners, children, community supports, animals and nature, (Moses et al., 2003). In other words, it looks at the need for people to have a connection to the world that is beyond just the self or self motivations. The results of studies for seem to promote the fact that participants of the ATRIUM program, "experience improvements in trauma symptoms" as wells as "a decrease in behaviors designed to cope with and help manage the impact of trauma, including self-harm, substance abuse, suicidality and aggression, as well as a decrease in intrusive symptoms," (Moses et al., 2003).

The other programs commonly used include TREM, TRIAD, and Helping Women Recover. TRIAD is a lot like Dialectical Behavior therapy in that the program focuses its 16 sessions on mindfulness, interpersonal effectiveness, emotional regulation and distress tolerance. The goals of this program differ from DBT in that they include goals regarding sobriety. The program is designed to promote, “survival, recovery and empowerment,” (Moses et al., 2003). It is also one of the few programs that allow for an open group so that group members can come and go as they need. This is also the only group that was created specifically for women who have experienced trauma as a result of violence. This program is still relatively new and has had only a few studies done on it, but it has been found “an increase in adaptive coping skills and a decrease in avoidance behaviors,” that are associated with substance abuse and trauma reactions (Moses et al., 2003).

TREM, which stands for Trauma Recovery and Empowerment Model, is an intervention that uses psychoeducational, cognitive behavioral and relational elements to promote survivor empowerment. This program is based on four assumptions. The first assumption being that, current dysfunctional behaviors such as alcohol and drug use, cutting and eating disorders to name a few, are coping responses that may have originated in response to trauma. The second assumption is that women who experienced repeated trauma, such as repeated physical or sexual abuse, were deprived of the ability to learn and develop certain skills that are necessary for coping in adulthood. The third assumption is that trauma severs connections at the innermost level to family, community and oneself. The last core assumption is that women who have suffered repeated abuse end up with feelings of powerlessness and thus never learn to advocate for themselves. This program seems like it would be useful to use in the beginning stages of treatment since it deals with many of the core issues regarding self esteem and helps women to

shed light on issues with stigma, in regards to substance abuse as a way of coping. This program is relatively new and seems to have been used mainly with women with more severe problems in regards to trauma and mental health issues. This program did report a decrease in intensive services such as inpatient hospitalization and ER visits as well as decreased mental health symptomology, (Moses et al., 2003).

Lastly, the program Helping Women Recover is a program that was, originally written to work with women who are incarcerated within the correctional justice system and suffering these co-morbid conditions of trauma and substance abuse issues. The program has recently, with in the last five to seven years, been brought out and used in more community treatment centers. This program focuses on, self, relationships, sexuality and spirituality with a gender responsive viewpoint. This program like previously mentioned programs, look at how addiction and substance abuse create a chronic neglect of self, in favor of others or a drug as a way of coping with trauma. This program differs from the other programs in regards to the fact that it examines with the women how being female has affected the ways trauma happen to them and how they process and deal with the trauma. It examines with the women the physiological, social and emotional consequences of addiction on their bodies and minds, and what being a women means with addiction and trauma issues will mean in their recoveries, (Covington, 2000). Research studies have found that this program helps patients to have greater reductions in drug use, and depression symptomology, (Covington, Burke, Keaton, & Norcott, 2008).

Adlerian Take on Trauma

Ideas of safeguarding and living by fictions, are both items that individuals suffering comorbid issues of substance abuse and trauma deal with, before coming into treatment. In the mainstream treatment culture, these ideas are known as coping tendencies and belief structures.

Using substances is the perfect example of a safeguarding tendency since as Oberst and Stewart (2003) define it, safeguarding is seen as, “Behaviors and attitudes that are designed to protect and individual’s sense of self-worth and self esteem from a perceived threat and the ensuing experience of inferiority feelings.” Individuals with trauma issues who use substances are usually trying to forget the traumas and cope with feelings of feeling inferior, since they were unable to stop the traumatic incident from happening.

Fictions are “imperatives of belief, of the ideal, of free will” (Ansbacher & Ansbacher, 1956), that individuals piece together to construct a sense of the world around them and these fictions can be good or bad for and individual depending on how he or she utilize them in understanding and setting up the world. After traumas the fictions or belief structures that individuals live by change because the individuals can come to believe that they are no longer safe, or worthy, or even capable human beings. When these negative beliefs are believed by individuals, they can start finding ways of coping or safeguarding through use of substances, cutting, restrictions on eating or dressing certain ways.

As Anbacher and Anbacher (1956) state, “Every individual acts and suffers in accordance with his peculiar teleology, which has all the inevitability of fate, so long as he does not understand it.” Bringing in these ideas of living by fictions and safeguarding tendencies is helpful in treatments because can help individuals to understand what’s happened to them and why they have reacted with certain coping mechanisms or safeguarding techniques. Some Adlerian techniques that are useful in the treatment of individuals with these comorbid issues are: genograms, and early recollections. All these interventions would be helpful in showing clients how substance use and trauma have tinged their histories and how the excuses they have used to defend behaviors have just been coping and safeguarding tendencies.

The use of genograms, in particular, can be used in many ways with clients with this comorbid history of abuse and trauma. The genogram could first be used to look at to see if there is any other history of addiction or substance abuse in the family. This would be beneficial to know as a therapist because since it can alert the therapist to look at the possible generational ways of coping or fictional beliefs, which are handed down within the family. It also alerts the therapist to family structure and family interaction patterns that may be healthy or unhealthy. As well as to where the client feels like he or she may fit in the family. Not only that, but genograms provides a guide for the client of possible family supports. The genogram can also be used to spot other possible instances of trauma or abuse-especially if it happened between family members or generations of family members and possibly erase the sense shame or feelings of stigma an individual feels about the trauma or abuse. A genogram helps to provide a pictorial representation of what has happened in a family. For some individuals it can be the first time they see a family history of their issues or family issues, or come to the realization that family beliefs or ideals may have played a part in their problems. Ideals and beliefs that they never even realized they were accepting and integrating into their beings when growing up.

One particular concept of a genogram that is helpful working with individuals with trauma issues is the Scripto-Trauma Genogram. This genogram is a new way of working with clients who deal with intrusive memories or flashbacks as a result of their trauma experience(s). It is like a mix of early recollections, EMDR and a simple genogram all rolled into one.

Like any other therapy that deals with trauma issues the client must be primed and readied to deal with the feelings and emotions that come up during the exercise. This requires the therapist help the client develop an anchor. An anchor is, “a concept that can serve as a tool by clients to get back from the traumatic event” and that helps to lower the hyperarousal that can be

produced as a result of re-experiencing the event. The anchor needs to be a concrete object or place that makes the individuals feel safe so that the individual can retreat to the object or place during the exercise as need be. Once this has been done, a basis genogram denoting how family members are related is done. The therapist should then start asking questions regarding the client's "individual, predisposing and protective factors," so that the client can have all these factors presented at the forefront to him or herself. Next a trauma timeline should be added to the genogram on the vertical axis, to identify any times throughout the individual's life when he or she may have experienced a trauma. After a client has picked which trauma he or she wants to talk about, the client is then instructed to write a narrative of what the most distressing moment of the trauma was. This is done so that clients can become aware of what the trigger(s) are that bring about the intrusive memories or flashbacks. After discussing this, the client needs to address predisposing and post-disposing factors that would have affected how the individual handled the trauma and the original after effects (Jorden, 2006). This is done so that the client can be made aware of all the factors that affect how individuals react to trauma. Once a client realizes this, he or she is then able to update and integrate the information from the original narrative, with what was discussed during the genogram exercise. This may allow a client to see how a trauma was not his or her fault, or how he or she were taken advantage of, or how he or she used all the resources available to them in that moment and still was not able to have stopped the trauma, but at least he or she was able to survive it.

Early recollections are also useful with clients who are dealing with dual diagnosis of addiction and trauma for many of the same reasons. The difference is that early recollections are more helpful after an individual has dealt with trauma. Early recollections allow the individual to understand why they have certain behaviors. If a client does enough early recollections with a

therapist, the client will see a pattern of behavior in the recollections. This pattern of behavior reveals to the therapist and the individuals what he or she decided was his or her goal of life is. The goal of life is usually determined by a child before the age of five, based on what he or she interprets from the environment. The goal of life is developed around beliefs regarding what an individual needs to do to: get love, feel safe, feel valued, etc. The goal of life though, can change if trauma or abuse of some sort happens. Going through early recollections after a client has treated trauma symptoms can help a client determine when their goal of life changed and how it changed because of trauma. This is also helpful for the client because it may alert a client as to why they turned to substance use to cope with a problem.

Summary

The results of trauma are devastating by when suffered alone. Clients who have suffered multiple or repeated traumas have their lives turned upside down. Traumas, especially sexual and physical traumas attack clients from many different modes. Not only do these clients have the physical wounds, they are left with emotional and psychological wounds. These wounds in particular attack the psyche of the victims and leave lasting impressions. Trauma victims are left with flashbacks, intrusive memories, elevated senses of danger, self doubt, low self esteem and even self hatred in some cases. Many times these symptoms are pre-cursors to a Post-Traumatic Stress Disorder diagnosis.

All these symptoms of trauma take their toll as victims of traumas try to treat and cope with them. Unfortunately, for some their method of coping involves substance use or alcohol use, which can manifest itself into substance abuse over time. When substance abuse and trauma symptoms are comorbid issues, how to treat the issues can become problematic. Thankfully, in the past decade or two, holistic, trauma informed and trauma specific, integrated programs have

been developed to treat trauma issues, substance abuse issues and other mental health issues that result all at once. These programs are set up in various ways from in-patient to out-patient settings, and with different treatment techniques. Many of the programs are psychoeducational in nature when treating the clients for substance abuse. The techniques used to deal with and treat some of the trauma issues are Dialectical Behavior Therapy, Eye Movement Desensitization and Reprocessing therapy, in-vivo exposure therapy, and even certain classical conditioning techniques. Add to these techniques use of early recollections, and genograms and clients with suffering from the comorbid issues of substance abuse and trauma reactions should be able to get through them with some help issues with help from family, friends, therapists and treatment workers.

Since trauma and substance abuse issues have such long term and devastating issues on everything from attachment to others to self-worth, not to mention the societal impact, this is an issue that needs to be addressed with new vigor. No one should have to suffer trauma reactions after the fact and more needs to be done right after a trauma event to make sure that victims of trauma are receiving medical as well as psychological help. Only with this kind of preventative care can trauma reactions and comorbid substance abuse become short term and possibly extinct issues.

Conclusion

Trauma reactions can happen to anyone, no matter if it's the loss of a loved one or abuse at the hand of a family member that have caused the trauma. The best treatment for dealing with trauma is to talk about it and get the feelings and events out into the open. Pain once expressed can no longer eat its victims alive. Unfortunately for many individuals, the abuse that many times precedes trauma has trampled any sense of self-esteem and clients feel embarrassed and

self-blame. This self-blame many times is the trigger that starts trauma reactions because clients don't talk about the trauma because the clients believe that talking about it will make them feel more responsibility for the abuse or trauma.

The many treatment programs discussed in this paper work on rebuilding the client's skills, and thus in turn their sense of self esteem. Many times this is the first step in a long process of rebuilding the clients up so that they all believe that they are worthwhile individuals. The treatments discussed almost all revolve around cognitive behavioral therapies because clients learn these negative behaviors, many times, to survive their traumas. Many of the clients have been in fight or flight mode trying to survive for so long because of abuse or trauma reactions, that to act in a way that would be considered appropriate in society scares them because it feels like letting down one's guard and opening oneself up to the possibility of being attacked. Thus, clients resign themselves to drinking or using substances to deal with the pain and mute the feelings of embarrassment, inadequacy and pain.

Thus, to treat these clients the treatment needs to be multi-faceted and holistic. These clients need not only the typical drug and alcohol education that clients receive in regular addiction treatment, but also need an all encompassing treatment that deals with self-esteem issues, everyday living skills, family, health and well-being. These clients many times need to learn a whole new way of living that lets them take in their past and integrate it onto who they are today without letting it destroy them. For many clients they need to learn to see their abuses or traumas as a badge of courage that denotes that they have survived more than most, and lived through the traumas to tell their stories about it.

It is the opinion of this writer that all the treatment programs discussed that are in use at present, are all excellent programs for certain populations. These treatment programs each work

great, each with different, certain segments of the population. They seem to all lack in follow thru after the initial program is done. All these programs are all great at teaching new skills and ways of thinking to clients, but do not provide supports to help clients in adapting these new skill and supports into their lives. These programs need to develop an aftercare like program where clients can come in and discuss any issues that have arisen or new feelings that may be coming to the surface because of the new life they are living and decisions they are making.

If this author were to develop a new treatment program it would follow in the steps of the treatment models already being used but would also include some Adlerian techniques to help clients find out who they really are and what their purposes are in life. Many of these clients have lived to survive and do not know themselves or even what their wants and needs are. Part of the recovery process needs to be finding themselves. Once a client finds him or herself, the client is better able to figure out coping techniques that play up the individual's strengths. Therefore if a client feels confident about what he or she is doing they are more likely to keep doing it during a time of stress to cope. As a therapist, this author would also make sure that while the program has psycho-educational components for clients to learn from that the clients also have group as well as individual therapy session to help clients deal with and work through the problems as they arise.

As can be seen throughout this paper the effects of addiction and trauma are life altering, especially when suffered co-morbidly. These effects are not just felt on a individual level by those who have been traumatized but are felt on a systematic level throughout society. Those individuals who have suffered trauma are many times the same individuals that are suffering housing issues, marital issues, and family issues. These effects of abuse and trauma affect all these areas of life and more. To help society become better, we need to stop just trying to treat

the peripheral problems but work on providing the funding and support to treat the issues at their cores. There are no band-aid fixes in the treatment of trauma and addiction, these issues need in-depth examination and work.

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