They're Just Wired Differently: Women, Addiction, and Treatment

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ONTRACK PROGRAM RESOURCES

"They constantly tell their stories…sometimes even with words."

Lisa Najavits, *Seeking Safety*

Understanding Change:

- Denial is typically a product of shame & punitive sanctions (encourages lying not truth-telling)
- Ambivalence and resistance to change are natural, not pathological
- Addiction is a relationship. Tx must offer the same support - or respect that it can't

Drug Education 101:

- Drug, Set, Setting*
- AA is not the only way (in fact, it can be harmful to women w/trauma hx)
- All use is not problematic use
- Stages of Change

*Zinberg, N. (1984) *Drug, Set, Setting: The Basis for Controlled Intoxicant Use.* New Haven: Yale University.

Good Drug Treatment:

- Defines success as "any positive change"
  - Sees obstacles like poverty, mental illness, racism, & more with trauma leading to: hopelessness, despair, self-destruction, self-defeating behaviors, abuse of others, & more
  - Understands that relationships, self-esteem, and self-care are needed to increase motivation for change
  - Appreciates that change is slow, incremental, and has setbacks
    - Knows setbacks (relapse) are the rule not the exception

Good Drug Treatment:

- Starts where the client "is"
  - Assesses the extent & meaning of dx use for each client
  - Considers clients' desired goals
  - Appreciates levels of ambivalence re: change(s)
- Shares expertise with client ONLY with permission
  - Helps client decide best choice for her drug/beh change
  - Is flexible with goals and methods of achieving them
- Assists clients implement their Change Plan
- Appreciates & understands – doesn't try to overcome – resistance

What is Trauma?

- An event or series of events that threaten you, perhaps even with death – that causes physical or emotional harm and/or exploits your body and/or integrity
- Trauma is pervasive and life-altering
- Trauma has been reported by 55-99% of female substance abusers (Najavits et al, 1998)

More on Trauma

- Trauma betrays our beliefs, values, and assumptions – trust – about the world around us
- Trauma leads us to engage in sometimes less healthy behaviors to help us through our reactions to these events. These behaviors
  - Are an adaptation not a pathology
  - What kept us alive to get us to services

Possible Responses to Trauma

- Intense fear; hypervigilance
- Feelings of helplessness
- Anxiety/Worry
- Intrusive thoughts & memories
- Flashbacks
- Depression

More Possible Responses to Trauma

- Anger or rage
- Nightmares & Night Terrors
- Detachment & Dissociation
- Substance Use & Misuse/Abuse
- Unusual sexual behavior
- Difficulty with relationships
- Others

Learning Objective #1:

Why do you think women initiate drug use (including alcohol & meds)?

Screening for Substance Abuse

- Ensure privacy & confidentiality (HIPAA)
- Communicate genuineness, respect, & belief in the client; build rapport
- Observe behavior
- Listen first; ask (OPEN) questions second
- Roll with any resistance!
  - "Denial" is a natural human protective coating, not a pathology

Post-trauma, women with SUDs…

- Improve less
- Worse coping
- Greater distress
- More positive views of substance use (understandably)

Connections btn SUDs & Trauma

- Witnessing/experiencing childhood family violence
- Childhood physical and emotional abuse
- Women in chemical recovery
  - Typically have history of violent trauma
  - Substances used to numb or dissociate - *medicinal*
- Violence often seen as a "natural" part of life
  - Coping mechanism for frustration and anger

What is Mental Illness?

- A medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others, and daily functioning
- Serious mental illnesses include: major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder

Thanks to the National Alliance for the Mentally Ill @ www.nami.org

Women with SUDs/Mental Illnesses

- Need safety to disclose chemical use
- May become disruptive when trauma hx becomes evident
- Face tremendous stigma
  - Seen as bad mothers or people
  - Seen as resistant to treatment or unmotivated
- Often most need these services
  - among those least likely to seek/receive services

PTSD does not go away with abstinence;

in fact, *it often gets worse!*

Learning Objective #2:

What impact does unresolved childhood trauma have on SUDs?

Adoptive coping strategies:

- Avoidance or 'denial' (numbness)
- Substance abuse & other addictive behaviors
  - Compulsive eating/food disorders
  - Compulsive risk-taking behaviors
    - Risky sex, driving fast or recklessly
    - Gambling or reckless investing/get-rich schemes
- Self-harm: cutting
- Control obsession
- Suicidal thoughts and/or attempts

Dissociation (complete numbing)

- Not mentioned in DSM-IV as symptom of PTSD though sx of acute stress d/o
- PTSD actually is a dissociative disorder not anxiety d/o?
- Crucial to understand process – it's the most severe consequence of PTSD

PTSD, Trauma & Consequences

- Varies due to:
  - Age of survivor
  - Nature of trauma
  - Response to trauma
  - Support to survivor afterwards
- Survivors suffer reduced quality of life
- Body signals can cause relapse
- Ability to orient to safety & danger decreases

Learning Objective #3:

What is the main common factor in women with SUDs?

Traditional Tx Approach

- Deficit model; focus is on problems
- Single trauma event = single effect
- Expected and definable course of treatment & recovery
- Client is defined by their problem (ie, liars; borderline; addict; resistant, etc)
- Treatment is typically crisis driven

Learning Objective #4:

What are the key components of trauma-informed, gender-responsive services?

Through love,
pain will turn to medicine.

Rumi

Trauma-Informed TX Services

- Competence model – sees strengths
- Client's worldview is due to trauma
  - Distrust, danger, confusion and self-blame are normal
- Sees how dealing with stresses of trauma causes clients to adopt less healthy ways to behave
- Appreciates early traumas inform later complex coping skills, continue to develop over a lifetime
- Understands trauma informs client's identity even when not realized

Trauma-Informed TX Services

- Emphasis is on whole person – how you lead your life.
  - "How can I come to understand this person fully?"
- Focus not just on functioning
- Agency message becomes "your behavior makes sense given your circumstances"
- Clients & staff begin to see clt behaviors as coping & brave, not pathological/unhealthy

Trauma-Informed TX Services

- Trauma seen as complex PTSD resulting from chronic &/or repeated stressors
- Strength-based approach
- Clients actively involved in all aspects of tx planning & services
  - We are equal partners

Trauma-Informed TX Services

- Safety guaranteed - not from other clients but from perpetrators
- Priority is on choice and autonomy
  - Client becomes Change Agent – Empowered through increased self-efficacy!

Trauma-Informed Services…

- Ask: Are our policies and procedures, program, hiring practices, etc. all in line with preventing the re-traumatization of the client?

OR

- Are we letting our rules – defined as the need for safety - actually mimicking any dynamics of an abusive relationship?

Remember:

- PTSD affects about 7.7million US adults
- Women more likely to develop PTSD (than men)
- Some evidence susceptibility runs in families
- PTSD often accompanied by: depression, SUDs, other anxiety d/o's

Thanks to NIMH @ www.nimh.nih.gov/health

What else can we do?

- Listen more than talk
- Gently help clients link SUDs & trauma
- Discuss current - not past - problems
- Listen to client behaviors
- Get training
- Appreciate that substances *do* solve PTSD/trauma sx

Language is crucial:

- Abstinent, sober, or drug-free
- Powerful; empowered
- Women united for women
- Supportive relationships
- Not "clean"
- Not "Powerless"
- No "Gossiping"
- Not "enabling" or "co-dependency"

What shouldn't we do?

- Don't explore past trauma(s)
- In general, no psychodynamic work at first
- No autobiographies until stable
- Don't ask about the trauma or the triggers
  - Gently guide conversation to present problems
  - Use complex reflections to highlight strengths

Above all, be cautious – go slow

There is great danger in re-traumatizing clients!

First, do no harm

"We should be humbled in the presence of our clients for *they* are the heroes of their lives."

--- Scott D. Miller

ACKNOWLEDGEMENTS

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Thanks for coming!!

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