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Treating Early Life Trauma Related Issues in Early Recovery From Addictive Disorders

Welcome to the growing family of coursework participants at CEU Matrix - The Institute for Addiction and Criminal Justice Studies.

This distance learning coursework was developed for CEUMatrix and is based on a live presentation by Cardwell C. Nuckols, Ph.D.

This course is reviewed and updated on an annual basis to insure that the information is current, informative, and state-of-the-art. This package contains the complete set of course materials, along with the post test and evaluation that are required to obtain the certificate of completion for the course. You may submit your answers online to receive the fastest response and access to your online certificate of completion. To take advantage of this option, simply access the Student Center at http://www.ceumatrix.com/studentcenter; login as a Returning Customer by entering your email address, password, and click on 'Take Exam'. For your convenience, we have also enclosed an answer sheet that will allow you to submit your answers by mail or by fax.

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About the Instructor:

Dr. Cardwell C. Nuckols has been described as "one of the most influential clinical trainers in America". For over 30 years, he has successfully served the healthcare industry in multiple capacities as a clinician, supervisor, program director and hospital administrator. Dr Nuckols has led numerous corporate start-up and reengineering projects including involvement in the development of three publicly traded companies. One of these corporations is helping to bring to market new medications to help those suffering from the devastation of AIDS. For his entrepreneurial efforts, Dunn and Bradstreet nominated Dr. Nuckols to receive placement in the 2004 National Business Registry.

Dr. Nuckols is widely published, having authored more than 50 journal articles, 28 books and workbooks, 32 DVDs, CDs and videos, and 17 audiotape series. Dr Nuckols first book, Cocaine: Dependency to Recovery, is a trade best seller, as is, his booklets Quitting Heroin and Quitting Marijuana (Hazelden). He is the author of the book Healing an Angry Heart (HCI) and video Chalk Talk on Drugs with Father Martin (Kelly Productions). A series of workbooks on "Adolescent Disruptive Behavior" and a CD on "Anger Management" has been released by Hazelden Publications as a part of their Adolescent Co-occurring Disorder Series. Dr Nuckols recent works include four DVDs entitled The Evidence Based Treatment of Co-occurring Disorders, A Research Based Approach To The Treatment of Anger, & Aggression In Early Recovery, Treating Early Life Trauma Related Issues In Early Recovery From Addictive Disorders and The Science Based Treatment of Addictive Disorders. He has completed a four part video series entitled "Breaking the Chains" of Addiction; *Using Science to Aid Recovery* and is developing a patient education and workbook series entitled "Discovery To Recovery". This series will utilize the latest scientific research to assist alcoholics and addicts in their personal recovery.

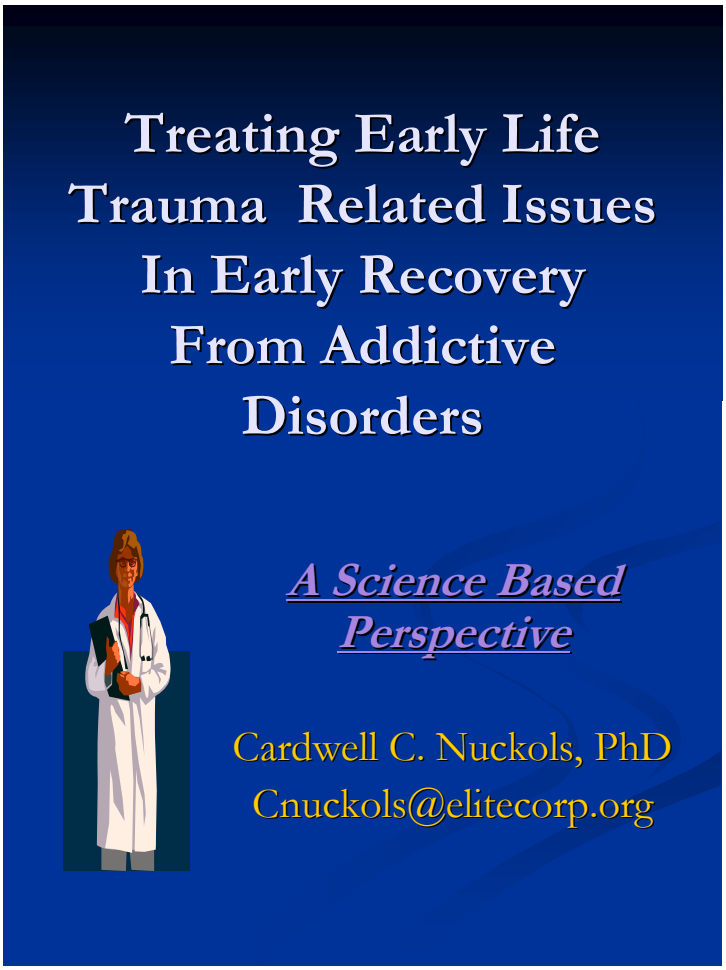
During his career he has been awarded national honors including the SECAD, Swinyard and Gooderham awards, as well as, being recognized for his contributions to The American Society of Addiction Medicine's Patient Placement Criteria. Dr. Nuckols is on the review boards of Counselor Magazine and the Dual Network and is an active member of the American Association for the Advancement of Science. He writes a column entitled "Pharm Report" for Counselor Magazine.

Dr. Nuckols' educational background includes advanced work in medical research, pharmacology, education and psychology. His practical approach comes from working with people in various business and clinical settings. Dr Nuckols has consulted with The Central Labor Council (AFL-CIO), United Auto Workers, Stouffers, Boeing, Dupont, General Motors, Bechtel-Bettis, Ford Motor Company, United Airlines, and other industries in the area of enhancing

productivity. He served as a trainer and consultant to the Federal Bureau of Investigation (FBI), federal court systems, and branches of the armed forces specializing in the areas of antisociality, violence, and trauma.

Using the Homepage for CEU Matrix - The Institute for Addiction and Criminal Justice Studies

The CEU Matrix – The Institute for Addiction and Criminal Justice Studies homepage (www.ceumatrix.com) contains many pieces of information and valuable links to a variety of programs, news and research findings, and information about credentialing – both local and national. We update our site on a regular basis to keep you apprised of any changes or developments in the field of addiction counseling and credentialing. Be sure to visit our site regularly, and we do recommend that you bookmark the site for fast and easy return.



Course Synopsis

This course presents the primary elements and issues associated with early recovery from addictive disorders when early life trauma is a factor in the recovery process. Issues such as neglect, control, abandonment, trust, safety, stabilization, and affected brain areas are presented. In addition, the course discusses some therapeutic interventions and future directions for treating addictive disorders. The course draws not only a sound clinical foundation, but also the rich personal experiences of the instructor.

Goals: The goal of this course is for the student to understand the primary elements and processes of treating early life trauma issues in early recovery from addictive disorders

Objectives: The primary objectives of this course are for the student to understand how the following affect recovery from addictive disorders:

- Neglect
- Trauma
- Drugs
- Hyperarousal
- Dissociation
- Alteration
- Depression
- Relationship Depression
- Physiological Changes
- Trauma and Physiological Changes
- Development
- Abandonment
- Social Interaction
- Control
- Brain Areas affected
- Multiple Dynamics
- Treatment Contracts
- Level of Care
- Trust and Safety
- Stabilization
- Medications
- Trust

- The therapist
- Safety
- Virtual Reality

Pedagogy: The primary learning methods for this course are:

- Reading Comprehension
- Visual Aids

Treating Early Life Trauma-Related Issues in Early Recovery from Addictive Disorders

By Cardwell Nuckols, Ph.D.

This course is about a subject that I think has been neglected in the field of alcohol and drug addiction for far too long, and it deals with early life trauma and how that impacts a person's life and ultimately how it affects their recovery. I think that for so many years we have had an injunction in our field that said a person has to be one year straight or sober before we could work on these early life issues, and I'll tell you that if you wait a year, you've got a client who is going to relapse two or three times in that year. We have people coming into treatment 10 to 15 times or more where the primary relapse issue is the old stuff—the stuff that happened in their homes and the abuse, the neglect—and is never really addressed. I understand in some treatment venues it is impossible to do this; but I think whenever possible if this is an issue that raises itself, let's make sure we get these people to some place that can help them because they're not going to have a good recovery. This is going to be, if you look in your treatment programs, about 2/3 and may even be ¾ of your chronic recidivists. If you knocked out the chronically mentally ill, about 2/3 to ¾ of your recidivists—your chronic recidivists—are going to be people with early life trauma history. So, in this course we're going to be talking about treating early life trauma-related issues in early recovery from addictive disorders, and I want to do this from somewhat of a signs-based perspective. What do our signs tell us in terms of what are the best treatments, and what does trauma do developmentally? What does it do to the brain? So, in the first part of the course, we are going to talk a lot about trauma and what trauma does; and as we get through that, we are going to start talking about specific treatment issues like, how do you deal with the hyperarousal and dissociation? Is there a way in early recovery to work with some of these trauma issues, and what is the limitation on who we could work with? These are the things that are presented in the course.

Neglect

The first thing I want you to do is imagine a beautiful little baby. It is very touching to me when I have a client who comes to me; and, for the first time ever, tells me about some of the things that happened to them when they were growing up and how much courage it must take to do something like that. I feel it is a very spiritual event, and I want to hold on to it in that way and understand that this baby sometimes never had a chance to turn out to be all that they could possibly be. Anything we can do to help them as teenagers/as adults to get the best they can out of life, the better off we should all feel about that. So, I think this is a very emotional issue for a lot of us. It's an issue that we have difficulty kind of getting our arms around and understanding. It is also an issue that science and research are coming out with a lot of new material now on neglect and on trauma. We actually understand now that neglect could be equally as devastating for a child, for example, as sexual or physical abuse. So, I think about the small child, and I think about this potential. I think a lot about what happens when we mistreat that child. What types

of problems do we see? What things can we expect when we watch this child as the child grows up through their toddler years, into their teenage years, and into their adulthood? We know that when you maltreat a child—when you sexually or physically abuse them, neglect them, emotionally abuse them—we tend to see more violent behavior in that child. If you start to look, for example, at your adolescent/adult criminal justice system, so many of the people in that system come from homes where they weren't given an opportunity; a lot of things went wrong. We know that we see more criminal activity in this population, more teenage pregnancy. About 10% of them become perpetrators of abuse themselves. They can, again, become a victim of trauma and actually be re-victimized more often. We see psychiatric disorders; we see substance abuse disorders. So, when we look at someone with a trauma history, we see so many other things that accompany them—sometimes charts that are very thick with all these psychiatric diagnoses in them. They're borderline, they're bipolar, they're this and they're that, they're depressed; and so trying to weed through all of that is sometimes quite a difficult problem.

Trauma

If we compare a neural image of two brains of 3-year-old children, on one side you see a normal child. On the other side you see extreme neglect. If you just look at the size of those brains, you will see the smallness of an extremely neglected brain. When a child is growing, they need many things. A lot of this is a mother's touch and love. Without these things, the brain does not develop properly. There are actually certain genes in the brain that actually get tripped when certain things happen in the environment; like when a mother sings to her child and looks in the baby's eyes and holds him. So, we see development from a love-bath perspective versus development in a Romanian baby factory. For example, if we look at the other extreme, and the types of consequences that come with this. Now, these people don't come to treatment most often giving you a story about being traumatized by their dad or mother or Uncle Joe. They generally come in because they're having problems with affect and impulse control. They come in with chronic feelings of self-blame, feelings of being damaged. These people have a lot of emptiness on the inside, and you can see where alcohol and drugs could really work for them in a very self-medicative way. We see the inability to form relationships. They tend to get into the same abusive relationships over and over and over again. None of them ever look like the past was a factor, but somehow they all seem to end up in just the same abusive relationships with alcohol and drugs involved. A lot of them come in with loss of belief in life. They come in contemplating suicide. Life's not working for many of these people. They come in often with self-medication attempts just to try to control their life. So, when we start to look at this and what people come into treatment for, they come into treatment for a myriad of things. Also, we know that people with a trauma history have a higher incidence, if you will, of multiple psychiatric disorders. For example, we can see attention deficit hyperactivity disorder, oppositional defiant disorder, and clinical depression. We can see bipolar disorder, phobias, and obsessive-compulsive disorder. We also see generalized anxiety disorder. So, one thing we see in this population is a lot of depressions, a lot of anxieties. We see certain personality disorders like borderline personality disorder. Again, if you look at this, a lot of this stems from their natural survival instinct. When one is fearful, you could see where one could develop a phobia to certain things. So, as we go through this, remember that the way these people come to us are many, many different fashions with many, many different stories with certain personality disorders like borderline antisocial. We see eating disorders in this population. For example, this is probably the predominant area for your eating disorder clientele. We see all the substance-related problems and somatoform disorders. When you start to look at this—panic/dissociative disorders—and when you start to look at trauma, you start to look at it from the perspective of addiction; it carries a heavy package with it. You can get all sorts of psychiatric problems, and all sorts of different diagnoses. Weeding through this, sometimes, is a very complex and very difficult process.

Trauma and Drugs

Now, let's look at substance-related problems, and let's ask this question: What type of substances would someone who has a history of trauma prefer? What substances would do the most for them? You might be surprised to know that opiates are the most desirable of all drugs for people who have trauma history. If you take opiates, basically it creates dissociation. Endogenous opioids, your endorphins, cause dissociation in the brain. So if we look at this, and we start to understand it; we can see that opiates from the outside might take up for the opiate deficit on the inside. We'll spend some time talking about that later. We see, for example, not only does it mimic the dissociative states; it can decompensate for lower levels of endogenous opioids like your endorphins and your enkephalins. Now, we can see them use alcohol and tranquilizers. PTSD, as we know, is an anxiety disorder. This is the disorder that a lot of the trauma might fit under in DSM-IV. So, if we look at this, we could say that if someone is anxious, probably something like a tranquilizer or alcohol would probably be drugs that would be desirable to them because it could reduce the anxiety, and make them feel a lot better. We also see a lot of use of cocaine and methamphetamine in this population. So the three leading (by rate now, not by number) drugs that we'll see are opiates, alcohol and tranquilizers, and cocaine and methamphetamine. Now, we're going to see nicotine dependence. We can see cannabis dependence. Remember that cannabis often covers a lot of anxiety, a lot of angers. We may see it used in a self-medicative way.

For example, let's look at a brief case study here. The case is a 28-year-old female named Karen with a history of drinking a bottle of wine and taking several Valiums prior to bedtime. Now, if I gave you this history, and I said I have a client that doesn't drink socially—they don't go out and drug—and the only time they ever drink is right before they go to bed. That would be an atypical presentation for an addict. I'd ask you, what do you think about that? Well in this particular case, Karen was a trauma survivor, and she had very horrible dreams at night. She had bizarre dreams of being chased, suffocated. So, what she would do is that she would drink and use the Valium or Xanax right before bedtime to help her get through the night without experiencing these horrible nightmares that she had. Another way of thinking of this is 34-year-old Michael with a history of using cannabis to medicate feelings of anger and anxiety. What we see here is a person who has a lot of anger, a lot of anxiety, who self-medicates it by using marijuana. That's why they call it "let's go chill out" or "let's go mellow out." So, we see a lot of substances used in this population, but predominately opioids, alcohol, sedatives, and the stimulant drugs.

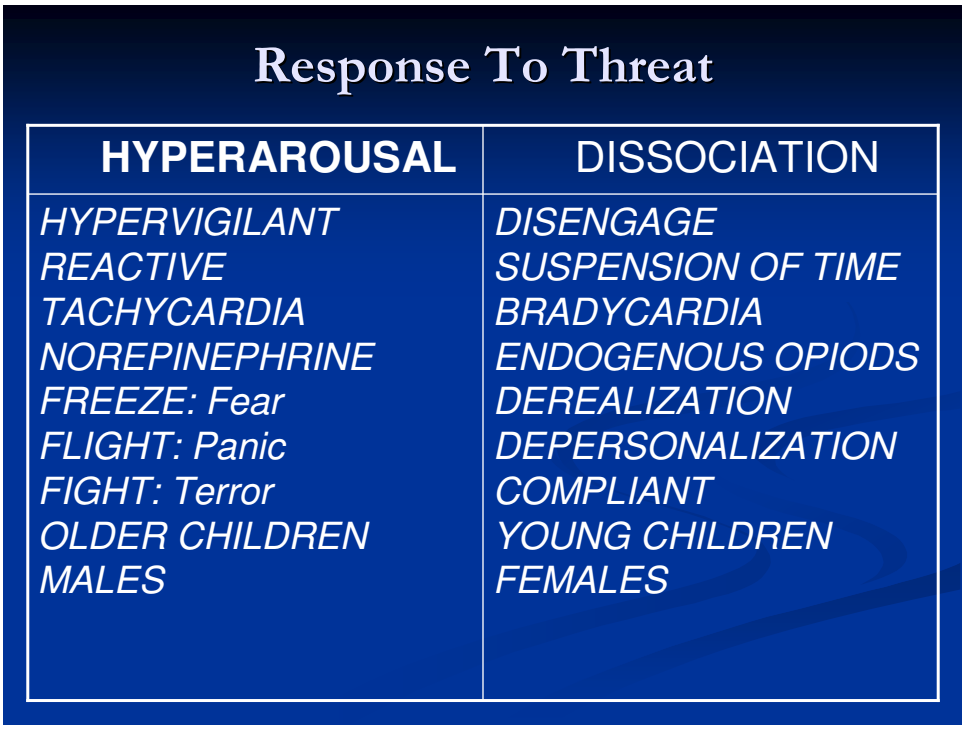
Hyperarousal

Now, one way to start to think about trauma is to look at how the brain develops. We know the brain develops from "bottom up and inside out." The first part of the brain that develops is the brain stem or the mid part of the brain. This is a part of the brain that controls inhibition, for example. The frontal cortex has to be well put together to be able to control the impulses from the lower part of the brain. This is something we talked about in a course we did on anger. When we start to look at this, the same thing holds true here. When you've got someone who is traumatized, we're seeing a well-developed brain stem diencephalon and not so well-developed frontal cortex or other cortical areas. So, when we look at this, what we see is strong hyperarousal symptoms. When we see these symptoms, it denotes poor recovery from alcohol and drug addiction. Let me explain to you the hyperarousal symptoms if I can. Have you ever worked with a client where something would trigger them, and they would go into just a pure fight or flight? What triggered them may be insignificant or really not much at all. This is what we're talking about. The problem here is that when they go into hyperarousal, they can't remember all that neat stuff that you taught them in therapy. So, this creates, again, a lot of problems. Now, we can look at this in terms of hyperarousal causing a fight or flight response, or they might also numb out. Now, when we talk about "numb out," we're talking about dissociation. So, what if we have a client who is in early recovery? Somewhere in early recovery the client may come upon a situation that reminds them of the old hurt. All of a sudden, they hyperarouse or numb off. Now, when they're hyperarousing or numbing off, they're not going to be able to use all the cognitive-behavioral recovery strategies that we've given him. So, here we've got this problem of hyperarousal and numbing off, which is taking the frontal cortex out of the picture. It is taking our problem-solving ability out of the picture, and the ability to use all the things that might be helpful for us in getting through the situation. So, we look at a response to a threat. We can look at hyperarousal and dissociation. Let's just look for a minute and talk about what we're seeing in this type of client. For example, in someone who is hyperaroused, they're hypervigilant. They're looking around for danger. You'll notice that in small children who are traumatized, for example, they look a whole lot like ADHD. You really cannot separate the PTSD-type symptoms from ADHD symptoms. They're very reactive. They have a very fast heart rate, tachycardia. A lot of norepinephrine gets kicked out. They can go into a fear or a panic. Often we see the hyperarousal more in males, especially older males who are abused.

Dissociation

But on the other side, we have dissociation, which is a numbing off. It's a kind of "checking out." Now, a person who dissociates basically just disengages. They just are not there for awhile. As a suspension of time, it's almost like a time warp; their heart can actually slow down. This is mediated in the brain by endorphins and enkephalins. Again—this connection—if this isn't working for me, if I take a little Vicodin or Lortab or methadone or heroin, I actually can normalize

myself. I can actually feel better when I use these drugs. We tend to see someone who is dissociated a lot more compliant. Dissociation probably in its severest degree is probably the most, I would guess, severe consequence of early life trauma. We tend to see depression, kind of PTSD symptoms, and dissociative symptoms at the top. Anyone who's had a history of trauma is probably going to have some depression. If it is a little more severe, we might see the PTSD symptoms. If it is even more severe than that, we start to see the dissociative symptoms come in. As we mentioned, these symptoms, especially dissociative symptoms, are found in females very early in life. They're traumatized because think—when you're 4 or 5 years old, what are you going to do when someone who is 180 pounds comes into your room? I mean one thing you can do is just leave. You can go to the ceiling. You can check out, and this is why our clients later on say things to us like, "Sometimes I feel like when I'm in a crowd, you know, I'm all by myself." "Sometimes I feel like I'm just watching myself in the ceiling," and we start to get these dissociative symptoms. Now, when a person starts to check out like this in recovery, they're going to have a lot of problems staying sober and straight. Also, they're going to have a lot of problems on their job; a lot of problems with relationships. When you just check out and your wife is talking to you, pretty soon your wife realizes you've not heard a word she's said. She's going to get angry at you. So, these are the things that happen sometimes in response to this threat that comes from these early life traumatic events.



Alteration

Now, let's discuss psychophysiological alteration. When we repeatedly cause chaos within the brain, and we continuously traumatize this brain; one of the things that we're going to see is that the homeostasis gets reset, right? Certain areas of

the brain change. The change can be for a long, long time. So, when we look at this, repeated hyperarousal causes an altered norepinephrine system—a much more developed system down here in the brain stem. We know that repeated dissociation causes an alteration in opioid and dopaminergic systems. So, we see people here who, the more they do this stuff, the better developed those areas of the brain are. What we're seeing as the consequence of this is that they're living too much of their lives either in hyperarousal or dissociation and not enough in the "here and now." In order for them to be able to use the therapies that we give them, they're going to have to be in the "here and now," and they're going to have to have a frontal cortex that's in charge of the situation. But if we looked at this in another way, a 36-year-old female with a history of early life trauma, currently in an abusive relationship, states she doesn't feel pain when hit or kicked. Any of you who have worked with domestic violence have probably had situations where the classic male knocks your client on the floor, and kicks her several times in the ribs. You ask the question, "When he was kicking you, it must have really hurt, didn't it?" A lot of times, they'll say no. They'll say, "But, in fact, 2 hours later I realized that maybe I had a broken rib, and I needed to go to the emergency room." So, thinking about it in this way, sometimes what we see is an altered system. In this particular case study, what was happening was that when she was put into a situation where there was crisis and violence, her endorphins and her enkephalins just escalated like crazy. She basically is able to kind of almost dissociate from the experience, and she doesn't feel that pain. But a couple hours later, the pain starts to come back. You may have run into a lot of clients or some of you out there may have had this situation of dissociating. It's a wonderful stress management skill if you can control it, but if you can't control it, it can create a lot of problems in your family.

Depression, etc.

So, in terms of looking at early life trauma, we see a lot of relationship here to depression. We see a lot of physiological changes. If you had to think about psychosomatic medicine—we all know about psychosomatic medicine—probably the trauma survivor, probably this population, makes up the best part of your psychosomatic symptoms. We will see a lot of correlation, for example, between irritable bowel syndrome and incest, and there are several studies that have shown this. One is in a serendipitous finding reported in *Psychiatric Annals* about 8 or 10 years ago. Three thousand women with irritable bowel syndrome: the serendipitous finding was that 60% of them were trauma survivors. This is the brain-gut connection. So, we do know that we'll see a lot of psychosomatic symptoms. We'll see the migraines. We'll see the abdominal stuff. We know that there's a lot of effect on development, and we'll talk about this. There's impact on the brain. There's a phenomenon called complex posttraumatic disorder, which is really what we see because the clients you see at an alcohol and drug treatment center, that come in with this type of early life history, do not present like DSM-IV PTSD. You may see some of the hyperarousal and the intrusive and constrictive symptoms, but you're going to see physical symptoms. You're going to see dissociation. You're going to see problems with self and identity, and we'll talk briefly about that in a

while. Also, you're going to see a lot of suicidal/parasuicidal behavior. So, what we've talked about so far is a client that's going to probably come in—if they've been in treatment—with a pretty thick file because these people have been to a lot of treatment. They're in over and over and over again. They come back in the same alcohol/drug treatment center, for example, 10 times. They could teach the curriculum, but no one's ever dealt with what happened on the inside because we've got to get to that hurt somehow because what's inside that person is a 7-year-old. Anytime they reach this stage where they hyperarouse or dissociate, it's that 7-year-old that's taking charge; it's not that 29-year-old. We've got to be able to take them from 7 years of age back to 29 where they can see things objectively, not subjectively--so they don't hyperarouse; so they don't dissociate, so they can use that cool stuff that you gave them in treatment and help them get through it without creating a potential relapse.

Relationship Depression

Now, we look at relationship depression. The most common outcome of trauma is going to be depression and posttraumatic stress disorder. You'll just about always see some type of depression. Depression may be a milder response to

trauma, as I mentioned earlier, while PTSD may be a little more severe response, with dissociative disorders being the extreme response. But remember, you're going to see a lot of overlapping symptoms between all of these, for example, depression and PTSD. When someone is depressed, they will tend to isolate. When you've got someone with PTSD, when things get too heavy and things get too intrusive, they constrict. They just pull back. Now, think of that constriction. "There are too many things around me. I'm starting to have too many of these flashbacks. I'm starting to limit my environment. I'm pulling myself back more and more." Can you see a phobia there? Can you see agoraphobia in that? Obsessive-compulsive disorder? Having to check to protect myself? Because their brain says the world is dangerous. So, we start to almost see the evolution of some of these anxiety disorders just by understanding some of the things that happened to them based upon their trauma history. So, I think the depression is going to be there. Maybe it might look more like a dysthymia at times, but I think you're going to see it. We're going to also see the physical changes, the physiological changes. For example, in many of this population you may see a high level of cortisol. Now, I don't know how much you understand about cortisol, but cortisol is a stress chemical that your body puts out. Now, what cortisol does, if it's there chronically, is really plaque out your immune system. It really destroys the immune system. For example, if you put high enough cortisol levels in someone, you can mimic every symptom that someone in AIDS has. You can actually end up with the sarcomas, the poor immune functioning with the pneumococcal infections, the pneumonias. So, when we start to look at this, cortisol does a lot of things. It is also the anti-aging chemical. So, you're seeing a lot of interest today in cortisols. This goes back many, many years for people who used to go to Romania to get the shots, if you remember Dr. Aslan, and these were anticortisols, actually procaine, that were being injected. What it did is, it made them look younger and feel more vital. So, cortisol accelerates atherosclerosis. It does something that is pretty devastating. It reduces the size of the hippocampus. Now, this is going to come into understanding in just a few minutes, but the hippocampus kind of tells us who we are because it really stores memory or distributes memory for storage. It is sort of like, I guess, a computer bank in the way that it does this, and you get this storing of memories. Basically, this is who we are, and so when we start to see shrinking of the hippocampus, which we generally see in depression, we see with posttraumatic stress disorder (you know, the trauma survivor), what we're going to have is a person who may have a lot of difficulty with memory, maybe holes in their memory and difficulty with their memory. Also, with cortisol, you see a lot of fatigue and depression. You see a lot of cortisol in all the autoimmune diseases--chronic fatigue, lupus (all of these), and rheumatoid arthritis. You may tend to see a lot of cortisol. You'll see norepinephrine increased in this population; and this really, in low levels, is a good thing.

Physiological Changes

Remember all of these defense systems that we talk about—freeze, fight, flight, dissociation—it's all about survival. We're built for survival. We're not built for joy and pleasure. We're built to survive. Now, the brain gives us certain types of

pleasure for certain activities like sex. We get a good dopamine charge from it. That means that we do it over and over again, so we perpetuate the species. Now we have drugs that do that. There are other behaviors like eating and dancing and singing that can create that, and that is sort of what I say is an evolutionary sort of plus. It's just sort of like something you got along the way that is a good thing that may not even have been intended. When we look at endorphins, what we see in this population is that they have a low endorphin/enkephalin level. Endorphins and enkephalins are what allow us to deal with anxiety and pain. So if we've got a person with low levels, what we find is when they go into a crisis, all of a sudden these levels become astronomical. If you've ever dealt with a nurse, for example, or doc who is a trauma survivor (and I can tell you from personal experience as I worked in cardiology for awhile), when someone would come in with an MI (a myocardial infarction), I basically went into the zone. I literally would dissociate. Everything slowed down. I was three steps ahead of everything. Like my heart would slow down. It's like everything is perfectly clear to me in that situation. You've heard of a football player saying when they run they're in the zone. They know where everybody is. It's similar to that. Now, what happens is, after this is over with and the crisis is over with, three hours later we're sitting in our room wondering why we feel so bad and not quite knowing why. So, these are some of the type of experiences that we actually found a correlation between the nurses choosing cardiac care, emergency room, ICU if they had a history of trauma because they seem to do better there. They do very well in that crisis situation. We saw it in Vietnam vets. We see it in domestic violence situations. So, this is something to think about. These are some of the physiological changes.

Trauma and Physiological Changes

Now, we talked about physical-somatic symptoms. Now, look at some of these things, the gastrointestinal types of symptoms, irritable bowel syndrome, migraines. Now please understand that I'm not saying to you that if you have a client who has a migraine or irritable bowel syndrome it means they had an early life trauma history. That's absolutely not true. All I'm saying here is there is an association between a higher incidence of some of these types of problems and having a trauma history. You see it more often. In their dream content, for example, you might see recurrent nightmares in this population. The nightmares are every interesting. When you have someone who is telling you about being chased, being suffocated, being chased and caught, these are typically themes that run through some of the nightmares that this type of client might have. So, none of this in and of itself is diagnostic, but it's pretty interesting collateral data. So, as we put the picture together, we start to see that there are a lot of different things going on here. There are a lot of different physical changes. There is an association between a lot of psychiatric disorders. There is an association between the types of drugs they use, and the types of dreams they might have. So, again, when we put the picture together, all of these little bits are something that is going to be helpful to us in understanding them. The other thing that we see is vaginal-rectal pain and itching or vaginal-rectal infections. A lot of these clients will not go to a doctor. Imagine, for

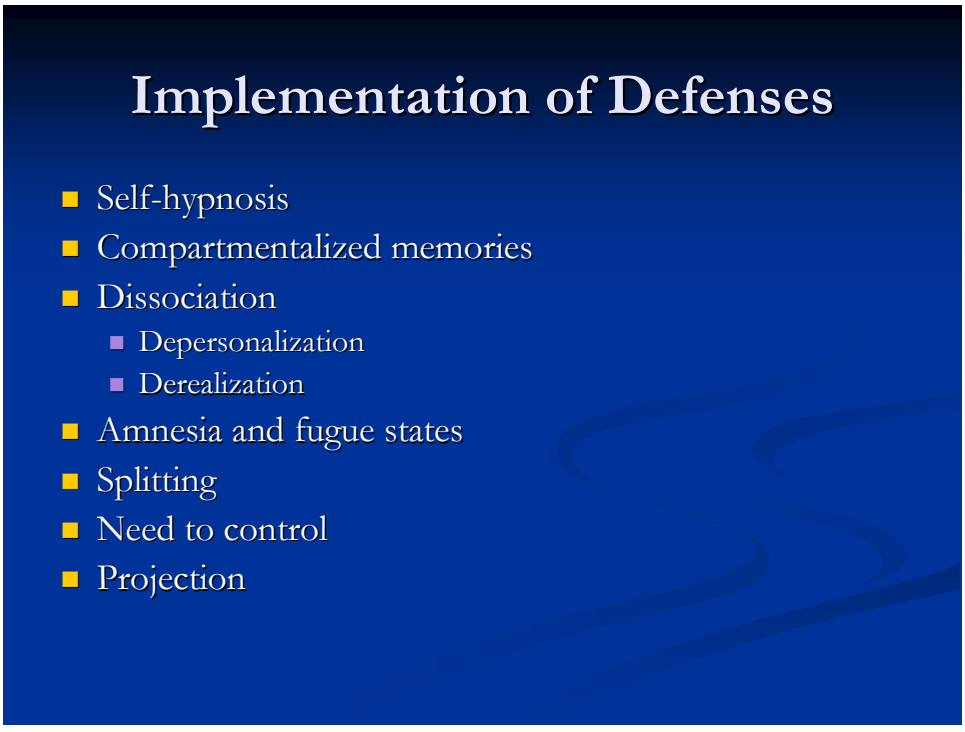
example, you're a young female and you are sexually abused. What must be your experience when you're put up there with your legs in the stirrups waiting for some guy in a white suit to walk in and examine your private parts? What kind of experience must you have? That's a terrifying experience. It brings all of that stuff back. You've got a father figure walking in and you're in this vulnerable position, so you can think that common sense might tell us with these types of clients, if it's a female, for example, we spend a lot of time trying to find a good female gynecologist and try to reduce the amount of resistance and the amount of trauma that they go through in trying to go through something like this. I've had clients who had nausea in anticipation of sex, especially oral sex. They would actually get nausea. I've had several clients who would vomit and that's from being forced to undergo these things when they were small children. So, you can imagine again the relationship, the association.

Now, if you look at some of the other conditions—fibromyalgia, chronic fatigue, chronic back and neck pain sometimes in this population—it is something that we might see. When I was in medicine, we would have clients who would come in with a lot of these types of disturbances, and we couldn't find anything to cut out or we couldn't find any pathology, and we didn't like them. We called them bad names. We'd send them to the psychiatrist, and the psychiatrist would see them and put them on an antidepressant. It kept kind of going like this. We didn't appreciate at all where these people came from and the hurt they brought with them because we weren't trained in that. We just didn't understand it. Now, I think today we've got a lot better understanding of these things.

Development

Now, let's look at this from a developmental perspective. We have been physiological; now let's look at it developmentally. The more different ways we can look at this, the better off we're going to be. What we want to understand is this whole person from as many different perspectives as we can. Now, we look at development. We want to look at aspects of development. What might happen in the implementation of defenses? I'm not going to talk about AIDS, but it is correlated with AIDS. You see different symptoms at different ages, for example. In adolescence you might start seeing more of the acting out. Someone who has been traumatized is going to try to interpret what happened. They're going to try to make sense out of it. Most of our clientele that we work with who have issues like this, and alcoholics and addicts in general, often have difficulty integrating feelings and thoughts. Have you ever noticed that? They have difficulty putting feelings into words. What happens is that if you look at left-right side of the brain, one is more thought oriented, one is more feeling oriented. The way the brain works is left to right and back and up and down or down and up in a circuit. So, when we get to a situation where we've got someone who has severance of the thoughts and emotions, what the cortex does is come up with excuses for it because it has to figure out a way to interpret it. Maybe it comes up with something like a rationalization like, "In order to be loved, you must be hurt." This is where we see

denial, rationalization, and intellectualization. The cortex makes these defense mechanisms to separate the thinking and the emotions because it hurts so badly. Part of our process in treatment is to try to get them to do this. Autobiographical things are one of the best ways to do it. Telling one's story, for example, is a beautiful way of integrating thoughts and emotions. So, in looking at this, I talk often about the neuroscience of psychotherapy, and part of the neuroscience is really getting the thinking and feeling to integrate and to a great amount of what we do in treatment. So, we can look at these different aspects. Again, let's look at development. When we've got people who are traumatized, they tend to grow up to be strong visualizers. They are very hypnotizable. They can dissociate a lot, and they have a lot of repeated memories. They also have problems with attention. Imagine, if you will, I'm in a hyperaroused state. I'm interested in what's going on around me. I can't hear what the teacher's talking about. I'm more interested in checking out my environment all the time. So, when you start to look at this, we can see problems with attention and obviously self-esteem. This person may feel like damaged goods. "I'm no good. No one can fix me. There's something mechanically or fundamentally wrong with me." We see here problems of attachment, problems of abandonment, and these types of issues that we see so often in treatment.



Correlated With Age

- Preschool
  - Cognitive impairment
  - Severe stress reaction
- School age
  - Aggression
  - Impulsivity
  - Destructive acts
  - Fearfulness

Correlated With Age

- Adolescence
  - Anxiety
  - Depression
  - Obsessive thought
  - Phobic/counter phobic

Abandonment

For example, I'll present a discussion about abandonment here. Have you ever had a client who right before you got ready to discharge him acted out? All of us have had those clients. A lot of time this is abandonment fear. So what happens if you look at this in sort of a schematic as a person with a trauma history and because of that trauma history and the way they were brought up, there are going to be attachment problems. The template they have of who is mom and dad in their brain is a template of someone who either was absent or was angry or abusive. So, when we start to look at this, with this template and we go out into the world, what kind of people are we going to naturally gravitate to, to have relationships with? People just like them, right? Have you ever sent a client like this to an NA meeting and see them fall in love with the absolute sickest person in that meeting. They come back to you and they say, "You know, I know that the two of us together can have a much better recovery than either one of us alone." It sort of leads you to say, "Well, why not? You've got 12 hours of recovery between you. That pretty much qualifies for a wonderful recovery relationship." These types of things happen as we understand the client, so we can explain them. We can understand where they come from, but people who have attachment problems often have abandonment fear that you're going to abandon me, and you're going to leave me. So, now they're connected to you. You're a parental figure. As a therapist, you're a parent. So now, you're a parent and you're saying, "Okay. I'm going to discharge you tomorrow." So what happens to this type of client is they have what's called abandonment fear. When they have abandonment fear, impulsivity goes up, and they start to act out all over the place and we see the drinking and the drugging. As a matter of fact, I get a lot of these people who will come back and sit in front of me, for example, in individual counseling, and say something like this: "I drank last night," with no emotion attached to it. When people relapse it's an emotional thing, but these people come in, "I ate last night. I took a drug last night." The message I think they're saying is that I'm not okay. You can't leave me yet. This is the focus of abandonment fear. I see this in the criminal justice system. We had a fellow who was 5 years down, 2 weeks to go, got up and hit a guard right in the face. He sat back on his mug, got 2 more years, and seemed to be pretty happy about it. It doesn't make sense, does it? But when you start to understand where they come from, it starts to make a little more sense. So, abandonment fear is something that can happen. The problem with this is that when they become impulsive, they may call us back up. We let them back in treatment; but after about 10 or 15 times of this, the staff gets a little burned out. They say things like, "Well, why would I want to spend 80% of my time on one client when I can spend this time with clients who really want to get well." That's not a nice statement, and I'm not trying to make a value judgment about it. In some ways I understand it, but if you think of it in another way; we should be flattered that this client's coming back to us because they think maybe we have something that can help them. So, when you start to look at this type of individual, what happens on that day when we say, "No, you can't come back into the treatment center?" Some of these people are really smart, aren't they? They know at 3 a.m. a certain doctor is working in the emergency room. They'll

come in at 3 a.m., and they'll show them a couple zippers on their arms. They'll say, "I'm going to really kill myself, and the only person that can really help me is Marie up on 3 West." The next morning, you walk in and all of a sudden that client's there; the same client that the team decided yesterday would never come back into this treatment program again. So, now you've got a clinician who is not too happy, right? So they're mad at whoever on night shift made this horrible mistake, and this is the way this goes sometimes. It is an incredible cycle that is very, very difficult to manage.

Social Interaction

Now, if we looked at other aspects of development, for example social interaction, these people often have an inability to trust. Now, that makes sense, doesn't it? If my exposure to authority figures in life has been one where I have been hurt, why would I be trusting of that individual? There's a possibility of re-victimization. I told you the templates. They have a tendency to pick out people who look like their parents—right?—to a great degree. It happens over and over and over again. We see it in the alcoholics, in the trauma, and it happens so much. Sometimes they actually victimize others, but that's not as much as we think. I think probably about 10% of our trauma survivors actually re-victimize their own kids and others. I don't think it's as high as we used to think it was. We see all sorts of problems with impulse control, and conduct problems. It is borderline personality disorder. There are two good studies showing 80% and 81% correlation between early life trauma and borderline personality disorder. Of those who are diagnosed borderline, 80% will have a history of a sexual abuse or some sort of other type of abuse. So, when we look at those correlations, they also bring a little something into the game because now we might have an alcohol- and drug-addicted, borderline personality disordered individual who cuts themselves. We may have the hidden eaten disorder and all the other pieces. I remember writing an article about 20 years ago, and I called it *The Therapeutic Waltz*. It seemed to me like with this type of client, you'd kind of get one thing under control, and something else would pop out. It was like trying to take one step forward and two to the side and a couple to the back, and it was so difficult to get everything stabilized. These people use a lot of defenses, self-hypnosis, dissociation, compartmentalized memories, amnesia, and fugue states. I had a client who had a little mini fugue state. She was in a jewelry store, and she had just gone through a divorce. She remembers being in the store, and she's holding silver napkin rings and her wedding band was silver. She doesn't remember what happened. The next thing she remembers, she is sitting in her car holding this silver napkin ring. She didn't know if she bought it. She didn't know anything that happened. She actually had that point where it was actual loss of a remembrance of what took place, which is diagnostic of a dissociation-- that place where they go away, and they don't have recall of it and time and space travel by. We know that they can split. They are very good at splitting the staff. This is a good borderline trip, where they have one staff being a "good mom," and another staff being a "bad mom." Now they've got the staff beating each other up. All of sudden, she thought the staff was doing wonderfully well. Now you come into the staffing.

Maybe the therapist had a wonderful little 15-minute session with his borderline. The nurses are always "bad mom" because they control the milieu. The therapist comes in and says, "I think Joanne deserves a few more privileges because she has been doing well this week." You've got the nursing staff using words you didn't even know they knew. All of a sudden, you've got a therapist, who is maybe a Skinnerian behaviorist, and a nurse who is some sort of transpersonal Bhagwan Marxist or something. You felt like this morning we were doing so well together, and now all of a sudden, we couldn't be further apart. So, these things happen.

Control

Remember these people have an ultimate need for control. This is again what we see, obsessive-compulsive sorts of things. So, when you start to look at control, you might have a meditation you're doing and ask all your clients to close their eyes. These people may not be able to close their eyes. You have to be okay with that and let them keep their eyes open because they feel out of control when they close their eyes. A lot of these people project. They can project their own feelings into you. Have you ever had a client who came in to you and said something like this: "I hear you're angry at me. Wanna talk about it?" You hadn't even thought about it. Then you go, "Where is this coming from?" Well, basically, you handle that by transference analysis, okay? "No, this is where I'm coming from, and this is your anger." We try to help them understand where it's coming from if nothing else. So, again, we see quite a few things here to work with, don't we? I mean, this comes in, and there are lots of different types of things going on at the same time. Trying to get your arms around all of it is a difficult task. They try to interpret the trauma themselves. I mean, if you're hurt, you want to understand why. The brain needs to understand why. The brain strives for closure. If I said to you, I want to see you tomorrow because we need to talk about your job. You'd probably think all night about, "What the heck! I'm going to get fired!" You'd probably become very catastrophic. I may want to promote you, but what happens is you're going to come up with a reason for what's going on. Your brain has to do this. So, what happens in this case, we might see them inventing explanations. These are some of the rationalizations that we talked about; the defenses they use. "People hit me for my own good." "People who love you, hurt you." "Life means suffering." I had a lady once say to me, "It must have been those fuzzy bunny slippers I wore." That was her explanation for why it happened, but the brain needs to do that. Remember, we're talking about a young brain, not a mature brain, trying to come up with reasons, and they don't have a lot to work with. So, when we start to look at this, these things may be cognitive pieces that we have to look at when we treat them. We look at the impact of the brain. There are brain areas that are very involved in PTSD, especially early life repeated trauma. When we start to look at these brain areas, we see some areas of the brain that are actually smaller than they should be because of the trauma. They're less developed—like the frontal cortex we talked about, the corpus callosum, the hippocampus—and we understand that these people really, if you look at a phobia, which a lot of them have, think about these clients as having a fear phobia. Think of it almost like a fear phobia because

what happens is the whole fear response. If you read what the fear response does, it basically comes into play when we start talking about hyperarousal and some of the other phenomenon.

Amygdala

So let's focus on some of these brain areas, and try to make some sense out of this--first of all, the amygdala. In the hippocampus, the amygdale, for example, we know the anterior cingulated is in the prefrontal cortex. These are areas in the brain that can be hurt by trauma. They can be smaller in nature. They may not function properly. Again, if we've got a prefrontal cortex that's not doing so well, we've got a problem. We've got a problem of more excitation over inhibition. Now remember, that if you look at the studies, the studies will tell us that these trauma survivors often see anger and threat where it doesn't exist. One study showed that when a trauma survivor was looking at a face that had sadness on it, they actually interpreted it as anger. What happens is they misread situations. They make a threat out of either nothing or minimal threat, and totally exaggerate it. This is hyperarousal again. So, these are some areas of the brain we're talking about. The corpus callosum, which connects the spheres; and the amygdala in here, which has a lot to do with issues around anger and lust and many different things like peer response. We have the hippocampus we talked about, which is involved in memory. Let's quickly go through some of these different areas of the brain. The amygdala has to do with fear—fear response—and it processes environmental threat. An environmental threat comes in through the sensory systems. We hear it, we smell (which is very powerful), touch; we see something that reminds us (smells are very powerful) of an old trauma. What happens is this information is processed in the amygdala. Sometimes what happens is we will create a fear response without any real threat or hyperarousal to very minimal threat. There is something going on here that is not quite right. Something's not doing its job, but what the amygdala does is trigger other brain areas to induce a physiological and a cognitive response. Now, if we look at this frontal cortex, as we will in a little while, we would think that if that frontal cortex was really operating well, what it would do is it would try to help us make sense out of that threat and start to ask questions very quickly. "Have I ever been in a threat like this before? What did I do? How did it turn out? How should I handle this?" If we knocked this frontal cortex out, this threat comes in and you slug somebody in the nose and worry about it later. But with the frontal cortex, the frontal cortex says, "Hey! Maybe the best thing to do is, since this guy is much bigger than I am, just walk away and kind of ignore it." So, when we start to look here, we have some problems, and a lot of the problems are communication between parts of the brain.

Hippocampus

The hippocampus, associated with storage and retrieval of memory, may be smaller and less active. The greater the decrease in size (which the evidence shows) in the hippocampus, the more the dissociation. There is a correlation

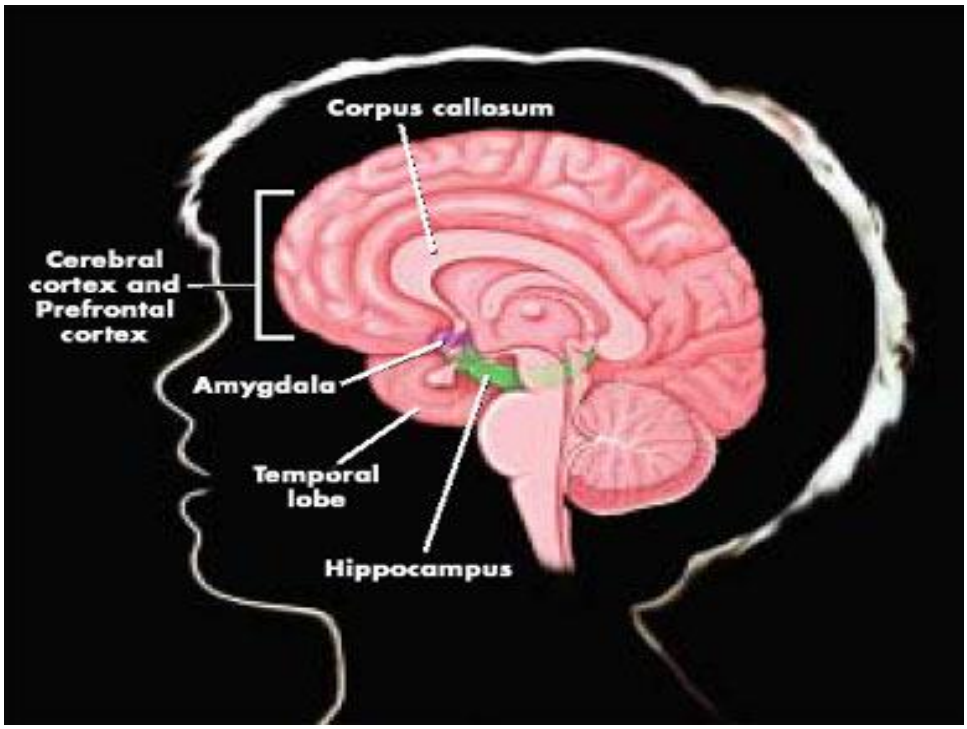
somehow between size of the hippocampus and shrinkage and dissociative types of problems. This may result in a deficient cognitive processing of memories. So, when we start to look at this, we've got this amygdala triggering a fear response. We've got this frontal cortex who is not able to sit on top and inhibit what's going on sometimes, and now we've got problems with our cognitive processing of what's going on. So, things aren't functioning so well. Now, the hippocampus really tells us who we are. If the hippocampus is damaged or hurt, we can have memory gaps, loss of context of memory, and we'll have trouble remembering things. This is an issue because in alcohol and drug treatment today, we're trying to get a lot of clients back into vocational training very quickly. Some of these clients are not in the position to get into training that involves a high level of cognitive learning like computer programming. We'll set them up for failure. You're going to have to wait some months before they're going to be able to do that, so we're looking at this trouble remembering. It's okay to maybe teach manual sorts of skills; but the highly cognitive stuff, they're going to struggle with. Now, remember, though, that certain parts of the brain are capable of regeneration: the hippocampus and frontal cortex. So, if we continue to get this person to work in a recovery oriented way, we help them look at their trauma issues. What we can start to see are some of these things getting better. It can actually grow new cells. It can repair damaged cells. We can learn different ways of living. We never make the trauma go away, but we can make life so much better for these types of people. If we look a little further, and we start to look at the anterior cingulated; this is a limbic structure. It also is involved in memory, in emotion. It also has a sort of a piece about it regarding selective attention. It is kind of interesting. I probably have problems with my anterior cingulate. I have trouble with my attention sometimes. When people are talking to me, I'm thinking about something else. It's really gotten me into problems with my wife. We've had to really work this one out because I check out sometimes. Because when I come home, I'm not the way I left. I've got stuff that's going on, and I really need a little time out. If I get that little time out, I can kind of ground myself and my wife and I can talk. My wife is one who wants to deal with it right now. She's a therapist, adult/child. So, we have it pretty interesting. This kid was a marriage made for Heaven or hell, I'll tell you that. We've been married 15 years, and it's working out pretty well.

Anterior Cingulate

We can see when the anterior cingulate is hypoactive. It can cause a failure of the cortex to modulate the response of the amygdala. Remember, the amygdala is the one that's processing the sensory input, creating the fear response, sending stuff out to different areas of the brain. So, when we have diminished cognitive control, frontal cortical control, who's running the ship? It is the lower parts of the brain. So, now we're in a reactive survival mode. Remember, that we're over seeing in many ways, over amplifying the threat. We're misreading the cues as we go along. So, again, these things are happening. Now, the prefrontal cortex has a role in regulating emotion. When it's running right, the cortex actually controls the action. It has the final say so in this. We have distinguished between true and

artificial threat. This is what the cortical area does. Is this a real threat or something to be concerned about? How have we dealt with it before? What should we do now? All this happens very quickly. The problem is it doesn't turn on normally in PTSD clients. They tend to misread the cues; they have difficulty distinguishing between threat and non-threat, but this area also is capable of regeneration and neurogenesis. So, again, we have the possibility in recovery of neuropsychological rehabilitation. If we get this person to do good things over and over again, think right, behave well, some of this old stuff that causes this hyperarousal, they can do some pretty miraculous things. I am seeing some wonderful outcomes.

Now, we're looking at PTSD patients, and the amygdala is very active. Now, if we look at a healthy individual, you don't even see the amygdala. That's without PTSD. No amygdala at all. So this is some proof of what I am telling you that this amygdala is very hyperactive. It is taking in all of these things from our senses, and how these things are processed is going to determine how this person acts. Now, if you look at someone, like so many of our alcoholics and addicts who are chronic recidivists, who are early life repeated trauma survivors. You can probably call this sanctuary trauma, being hurt at the hands of those who should love and care for you, is the most brutal hurt of all. If we start to look at this, a lot of times, this is multigenerational trauma. We start to see that maybe there is some genetic basis to some of this. They have actually looked at different gene coding for a certain dopamine transporter that may have something to do with vulnerability to PTSD or vulnerability to these symptoms. Now, this involves changes in physiology, self and identity, and dissociation.



Complex PTSD

- Repeated inescapable early life trauma
- Multigenerational trauma
- May have genetic basis
  - Gene coding for dopamine transporter (DAT)
- Involves changes in physiology, self and identity and dissociation

Multiple Dynamics

So, what have we talked about so far? We said that there are a lot of physical changes that can occur. Clients may have the migraines, the abdominal stuff, the dreams, all the other things we talked about. We talked about self and identity, from self-esteem problems all the way down to borderline personality disorder. Then, we talked about dissociation. So, these are the three variables of what Judith Herman, to my understanding, about 1991, first described as complicated or complex PTSD. Now, this is a little different than the PTSD you read in DSM-IV. This has got a lot of other elements to it. But to totally understand the clientele we're talking about, you need to understand all these different dynamics because you are going to see them playing out in front of you all the time. If we look at this and we start to look at, for example, working with this population of people, look first at suicidal/parasuicidal behavior. For people with trauma histories, it's not uncommon—especially if they're severely impaired and they have borderline personality disorder—it's not uncommon to get a lot of suicide threat/parasuicidal behavior (the cutting, the burning), and how do you manage something like that? I think that for me the best way I manage this is when I get the call, I go through the basic assessment. How serious is this? What's going on? But in the process of doing this—the crisis assessment—I ask them to go back to maybe an earlier time (this is especially good with borderlines) and tell me almost like a newspaper reporter, cognitively, using this part of your brain, what led up to your feelings of wanting to hurt yourself? I would say most of the time, you'll get an interpersonal slight or something like that has just been globally grown out of proportion. When we understand what that slight is, now we can work with them behaviorally, for example, to help deal with that problem/solve the problem, and then go right on. Because often the parasuicidal or suicidal behavior will not even be a problem we have to deal with then.

Treatment Contracts

Now, let's think about this patient coming in, and let's think about a contract in a situation like this. I would refer you to (in looking at this type of work), some of the books written on borderline personality disorder that get into contracting in these situations. You might find a lot more data on this if you're interested. Marcia Linehan probably is as good a place to go as not. I'm going to use a little of contracting and change it just a little bit. In this contract what I do, and especially if I've got someone who has difficulty with boundaries (which is probably going to be there)… Remember how we used to contract? "I want you to contract with me not to do this stuff to hurt yourself? You know, I really care about you?" Do you remember the contract? Well, with some of these people that can get you into trouble; especially, if they have borderline tendencies or they're borderline personality disorder with all sorts of problems with differentiation, or personal boundaries. Because what happens is, that they'll call your answering service at 9 tonight, and your answering service won't give them your home phone number, and they'll actually hurt themselves to get even at you. So, you know, to get out of that

trick bag, one of the things you can do is in the contract, you have a "patient responsibility part." As the patient, you're responsible for reducing the incidents of self-destructive behavior. So, instead of contracting with me; they're contracting with themselves. So, remember, what I'm taking of advantage of here is I'm getting out of a transference situation. So, what I'm doing now is I'm making this clean. It doesn't mean they're going to hurt themselves, but it gets me out of the middle of it. Then as a clinician, my responsibility is I'm going to always call the shot on this setting. When I'm doing the assessment, and I think the threat is too real that they might hurt themselves; I'm going to call the shot in this setting. I'll never negotiate that because I'm going to make that call.

Level of Care and Alternatives

Now, in many of these clients, I actually do a preamble in treatment where I say something like this, "There are two ways you can interfere with therapy. The first is life threatening when you call me up and say you're thinking about hurting yourself. I might have to put you in a more restrictive or safer level of care. The second is therapy threatening behaviors when you don't follow the rules, when you don't show up, and you don't cancel appropriately. You try to call me at home at 11 at night. That may make me mad, and I may need to refer you to someone else or discharge you." So, I'm thinking here that if I'm important to this client, if I'm part of the lifeline they're holding on to right now, that I'm going to have certain power. If they start getting out and violating the rules, that I can pull them back in. So, I set that stage right up front. We also give people alternatives. Remember the old alternative of sticking your hand in ice water until it really hurts? That's the first one I ever read 20 something years ago. I think that's not a very portable intervention. It's hard to travel with a cooler all the time, so what we do today is we do rubber bands. We do different types of things. Rubber bands might work (they really hurt) as one thing to do. I've had people use red markers and just slash themselves. I've had people who would put tape on their arms and draw a name and just do this. Somehow they get some relief out of it. In looking at this, though, what we can do is we can notice that these people often—if I had to put them in buckets—one bucket would say to me when I ask them, "Why do you hurt yourself?" They'd say, "Because I really have this need to hurt myself." Kind of nondescript. Another one will say, "Sometimes I just feel like I'm losing it. I'm just sort of floating away, and when I burn myself or cut myself, it brings me back." Those are your heavy dissociaters, and even the rubber band will work pretty well with those first two; but the third one it won't work with. This is the one who says, "When I cut and all the blood leaves my body, all the anxiety and pain leave, and I feel so calm." Have you ever heard that? Basically, these people are getting off, like taking a drug, and what is happening is that they're getting a dopamine surge in the nucleus accumbens/ventral tegmental reward center in their brain. They're actually getting off on this. They're getting something that's positive. It's hard to imagine cutting yourself and feeling good about it; but in some situations with these clients, that's exactly what we're seeing. So, if you look at this, we want to come up with some

alternatives. Again, the level of care is important. We want to determine what level of care is safe for them right now.

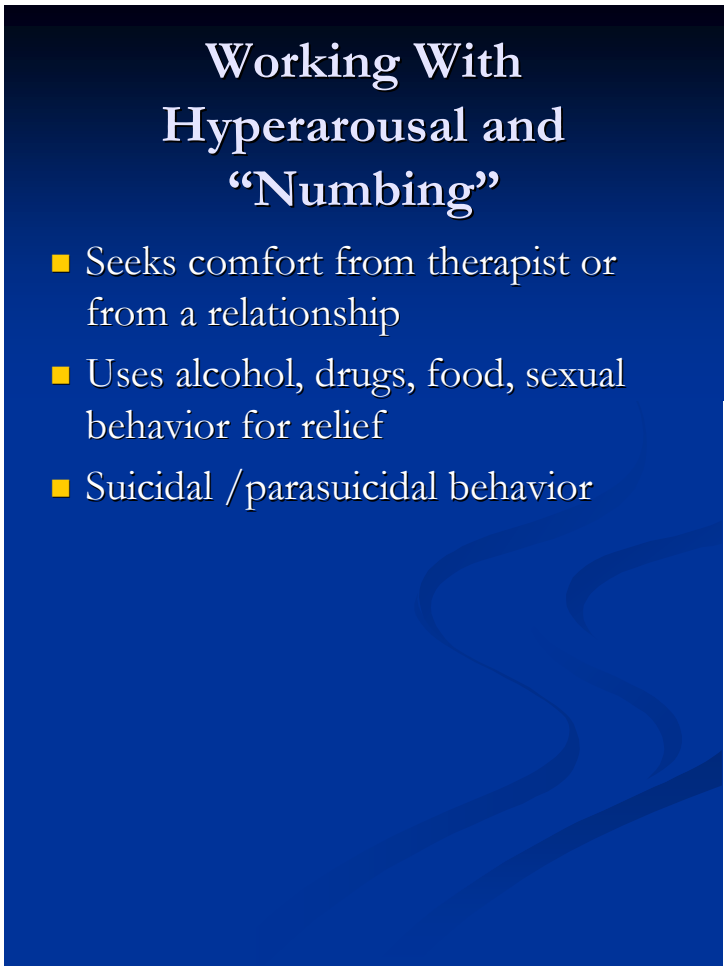
Trust and Safety

When we look at treatment considerations, there are some things that I think about right immediately. The first thing is your stabilization issues, trust and safety. I'm also going to think about working with hyperarousal and numbing off. How can I do this so that I can keep them centered enough so they can use the skills we're trying to teach them to get through this without drinking or drugging or having to turn to some self-defeating behavior to manage the pain they're feeling? Now, the psychotherapeutic options in looking at this, it is interesting, seem to indicate that trauma is more right-brain oriented. It seems that the research is telling us it's more right-brain oriented. So, what we have to do is to have a therapy that somehow creates enough excitation to get into that emotional area. So, probably what you're going to see here, even if you're doing something that is behavioral like behavioral exposure; you're still going to have a piece in that for when there's an exposure element to it that can trigger these particular memories in a particular area of the brain that we may see the trauma stored in. Well, let's turn to subjectivity. The terms I'm going to use with this are along the lines of subjectivity versus objectivity. I had a client, her name was Peggy. Peggy, when she first came to see me, had been diagnosed with everything, been on every medication that you might imagine. She had been in a situation where she was in a movie theater; and a young man tried to hold her hand, and she broke his nose. She walks into my office, and she tells me this story, and she says, "This isn't normal, is it?" Well, I should have sent that young male a thank you note. It really opened up things for her and in therapy, but the point that I was saying here was that when that young man tried to hold her hand and subsequently learning that her older brother was the perpetrator tells an interesting story, doesn't it? What happened was she just had this knee jerk, excitatory, survival, whack you right in the nose response. She understood that that's not normal, but she couldn't help it. It was built in. So, when we look at this, when she was back there at 7 years old, that's subjectivity. When she's looking through her eyes as a 29-year-old, that's objectivity. Part of what I want to do with the client is to take them from subjectivity to objectivity; or from there to here, because when they get in a situation that used to cause all the arousal, if I can keep them centered. If I can keep them looking through the eyes of a 29-year-old, they're going to be able to use those things that we've given them to try to get through the problem area. So, if we think about it in that way as a construct, it brings up the issue of trauma treatment in addictive disorder. Should we treat somebody's trauma issues in early recovery from addiction? This is a very emotionally charged issue that has been in the addictions field for 30 years. I think if you look at the data now, we're getting more and more positive data that says, yes, not only can this be done, but it can be done safely and very effectively. I've been doing it for about 20 years, but one of the things that I really do is to get to know a client very, very well before I'll do anything like that. We used MMPIs and clinical interviews to see who could go through it, but I'll tell you, it seems to me that when we look at this population there

are a lot of people we should never take through this--people who are psychiatrically impaired, or severely have co-occurring types of problems. We need to keep them out of this. A lot of them are not going to be tough enough to go through this without regressing, without actually causing harm to them. So, we need to know who we can work with, and who we cannot.

Stabilization, Trust and Safety

- What has changed?
- Closed contract
- Stabilization
  - Physiological
  - Psychological
  - Social
- Trust
  - Validate feelings
  - Map of the World
  - Rapport



Personal Reflections

In looking at stabilization, trust, and safety, there would be one thing that I would say to this particular type of client… I'll give you a couple of examples. We had Vietnam vets in Chicago a number of years ago who were marching after the war was over. We had a big march, and after that I had a flood of Vietnam veterans because they were around all their old pals and digging up the old stories. They were starting to have dreams, and the PTSD symptoms were starting to come to play. I had one fellow who came in with his wife. He didn't want to be there. He was there because his wife wanted him to come, and he was afraid he'd hurt his wife and family. This guy loved guns. He had guns all over his house, and they were loaded. This guy is waking up in the middle of the night back in the bush someplace. He's coming out of bed, and it's a dangerous situation. So, what do we do with something like that? In thinking through it, what do guns mean to a person who has been in battle? A source of power, isn't it? A source of control. If I were to yank those out from under him right now, it might make him worse. So, what we try to come up with is some creative way. Can we get him to unload the guns and put the bullets someplace else or just separate the two? That's what I was talking to him about. This is a case I made a grave mistake in. I remember all of my failures. I

remember every one of them. I'm never going to tell you that I'm a great therapist, but I'll tell you about every one I screwed up because they're mostly still now learning experiences, aren't they? I was very fortunate that no one got hurt this time. I guess I've been very fortunate as I have never had anybody kill anyone or kill themselves, and so I'm grateful for that—30 years—and I'm very happy about that. I'm just saying that because I retired a couple years ago from clinical practice, so I don't think I'm going to put myself in the place where it can happen again. I wouldn't tempt fate. But this particular individual says, "Well, I've got to come up with a plan. I know what I'm going to do. I'm going to take my guns, and I'm going to put them in a safe place." Well, I failed to ask this guy, "Well, tell me where that safe place is?" This guy is kind of falling apart. He's not doing so well. I'm supposed to be the one who had it together. So, I said, "Okay, that's fine. You're going to get them out of the house." So, that was looking good. The guy walks into a bank lobby with six handguns the next morning. It was my fault, not his. But you can imagine what could have happened.

Stabilization

But, again, in trying to coming up with a creative solution. People come in and say, "If I only hadn't of been on that side of town, I would have never been raped. This would have never happened to me." Have you ever heard something like that? That's an interesting statement. We'll look at that one too, but the first question I ask is, "What has changed?" The reason I ask this is why is it that this trauma survivor has been able to do fairly well, or maybe through the use of modern chemistry, they've been able to do fairly well. All of a sudden all heck is breaking loose, and they're having PTSD symptoms. They're having physical problems; they're having problems with nightmares. Why now? Just about always, what you're going to get, is you're going to get a story from them about something like the Vietnam vets marching. I had a client named Karen. When I first saw her, she didn't even come into the office. She stopped right at the door, and she said this to me, "I keep having these dreams. We're up in our cabin in New England. I hear my sister scream, and I say to myself, 'I have to help my sister.' So, I walk over to a banister and I look down, and there is my father on top of my sister. My mother is standing frozen by the door, and I say to myself, 'I gotta help her,' but my legs won't move. All of a sudden, my father looks up at me only in the way he could look at me and said, 'You're next.'" She looked at me and said, "Did it happen?" She was referred to me for alcohol and drug problems. Now, if I would have said to her, "Oh, well, I don't know, but let's talk about this alcohol and drugs that you've been doing." How improper could I be? How disrespectful of the client! We've got to be where they are. So, in looking at something like that, I have to bring this person in. I have to get them down. I have to start thinking about, "Geez! How am I going to stabilize this person?" What do I have that's going on in their case? But I asked, "What's changed? What's happened?" In the Vietnam situation, it was the march. In her situation, she had just moved from Pensacola, and she got a new job. She was going back to school, and she was starting to have dreams at night. She is totally disconnected from her family. She grew up in Pensacola. She is having these

dreams, and her husband is telling her she is crazy. He is blaming her for it. So, the night before she sees me, her husband leaves. This lady walks in with all of this stuff going on, with no support system at all, and tells me this story. Did it happen? Well, I could probably be pretty sure it did. But, I can't put words in her mouth. They're the ones who would have to say that, and that's what she is. So, when I look at this, I look at stabilization, physiologically, psychologically, socially. How can I stabilize this person? Sometimes this might mean a medication. Sometimes it may be behavioral. Sometimes it involves making sure they're going to more meetings; they're more in touch with their sponsor. I've had sessions where I've asked a sponsor to come in because what happens is when a person starts working on these issues, they'll tend to ignore their AA and their NA. Therapists, who get into this, find this is exciting stuff. We start to forget about the alcohol and drugs. This is a time when they need the most support, to go to the most meetings, to have a therapist, a sponsor, or someone around them more than not. So, physiologically and psychologically and socially, we want to try to stabilize these people. Well, with the Vietnam veteran, we can't change what has happened. In the lady's situation, we don't have family around, and family sometimes is the worst place to put them. So, how can we come up with something creatively for this person to hang on to? Now, when we start to look at this, it is a lot about trust and validating feelings and understanding their map of the world and establishing rapport. So in other words validating where they're coming from. In looking at this, it is understanding that this map of the world has changed. They look at the world different than other people do.

Treatment Medications

So, as we start to look at physiological stabilization, what I'm going to discuss in this course are groups of medications. This is probably pretty much up to date in terms of what has been most empirically proven to be effective with this type of client and this type of situation. For example, the FDA has approved both Zoloft and Paxil for treatment of PTSD. So, it won't be off label. It's actually approved because it's effective. It improves their memory and their concentration. It can be quite helpful to them. For dissociative symptoms, we use a lot of naltrexone or clonidine. Why would you think that we would use something like naltrexone? What is behind dissociative symptoms? What did we say about what type of chemical in the brain is involved in dissociative symptoms? Endorphins, enkephalins, internal opioids. So, what we do with naltrexone is: When they get that opioid experience, which is pleasurable to them, the naltrexone will block it. What we're doing is basically behavioral extinction if it works. In other words, if people continue to do things like cut themselves, hurt themselves, and they don't get anything out of it; behavioral extinction tells us that maybe they'll diminish the amount of times they use it and ultimately the behavior will become extinct. So, that's one reason for that. Clonidine, Catapres, as well Inderal, and propranolol have very good effect in terms of also shutting down some of the autonomic symptoms. It can be helpful in this way. Look at this, for example. I have propranolol up here under aroused and hyperactive. We could use propranolol or clonidine, but there has been some new

research that has been out. I don't know how long now, but not very long, that says if you have someone who has been raped/has been traumatized, if you can get to them within hours to a couple of days and put them on propranolol, that it is going to reduce the PTS symptoms and may even keep PTSD from developing. So, that's one thing of interest to think about. Propranolol, early post trauma, could be very helpful in diminishing the possibility of these symptoms. So, in an aroused hyperactive situation, we use propranolol with clonidine. Now, what we're doing here is we're treating symptoms. All we're doing is treating symptoms. There is no drug that we have for trauma. There's no drug we have for PTSD, but there are many difficult drugs that have been proven effective depending upon how the person presents. So, if we're a psychiatrist, we look at this person and we see if there are memory problems, concentration problems, dissociative symptoms, are they aroused/hyperactive, and we use different medications that will help reduce those symptoms. That's all we're doing here is basic symptom management. Someone may come in who was a very fearful, very paranoid, or even psychotic—and you can see this. I've seen a couple of episodes of brief psychotic breaks. For example, I had a lady in group once who stood up in the middle of group, and she said, "It's my father." She started talking about her father coming through the door. Now, her father wasn't come through the door, but she believed it. You handle this in a way you would with anybody else. You maybe hold their hand and you look them in the eye and you say, "Take your shoes off, feel the floor, make eye contact. The only thing here is you and me." You do basically a general stabilization if you can; and if that doesn't work, you may move on to a medication if necessary. But things like this can happen. So, we might get into more of the atypical antipsychotics when we start seeing things that look more paranoid or psychotic. When we have labile, impulsive, aggressives—we're seeing a lot of this in our borderline population,—the 27-year-old alcoholic addict with a hidden eating disorder who is sort of like Glenn Close in Fatal Attraction. An angry, demanding, seductive, never seen one come up out of the bathtub like that but wouldn't put it past them types of clients that we might run into. A mood stabilizer may be more effective with them, something like your lithium or your Tegretol or Depakote. Most people today like the newer medicines, the Tegretol, the Depakote, as opposed to the older medicine lithium. Baclofen has been shown to be an active gaba receptor, which improves symptoms of veterans with PTSD. That's another medication available. As I told you, propranolol can be given within hours to a few days after a traumatic event. In our country today, the leading cause of PTSD is car accidents. When you think about it, this is true. Have you ever worked with people who have been in serious head-ons? You know, the first time they get back on the highway, every car coming is coming right at them. The way you kind of get them through this is like dealing with a phobia. It is a little bit at a time. If we were wise about doing it and trying to expose them a little bit more, a little bit more. Don't just put them out on the freeway. It might be a little too much for them. So, again, these are things to think about if we're talking about physiological stabilization.

Psychological Stabilization

Now, how about psychological stabilization? Well, we can use our behavioral therapies, or cognitive or cognitive-behavioral therapies. Intrapersonal therapies here can work very, very well. Now, behavioral is more about decreasing stress. For example, we could create a safety plan; a 3 x 5 index card with various things on it—how to call a sponsor, what you can do when you are sort of feeling the symptoms arise—something they can hold on to--very behavioral, very stabilizing. We could use cognitive-behavioral strategies to help them decrease the confusion. Again, the cognitive, for the dysfunctional thought records might be very helpful there. I'm not going into great length here with the safety plan, dysfunctional thought record, because those were done in another course where we talked about anger in early recovery, but I did want to express to you that 3 x 5 index card. Put things on it. Things that they can do, that they believe will help them. You tell them that you always have to keep it with you, no matter where you go, even by the bed at night and in the purse/in the pocket. So when they reach a situation where they start to experience some problem, they can pull this thing out and have a rather grounding behavioral piece that can give them some direction as to what to do. On an intrapersonal perspective, we run into situations, as I'm sure you do, where the

couple you have may be someone who is in recovery, and all of a sudden some of these issues start to emerge. Because, remember, they've been keeping this stuff down with alcohol and drugs for a long time. Early recovery is not a particularly bad time for all of this stuff to come into consciousness to create difficulty, so you've got a spouse there who doesn't know what's going on who is wondering about the sanity of his husband or wife. In these situations, we need to enlist the help of the spouse. The way we would do that is through couple's counseling. We'd get them together. We would explain to the spouse what is going on so they understand and talk about how they can assist their loved one in recovery as opposed to reacting in ways that may make it even worse. So, I think a lot of times in these situations where couples are involved, we really want to get the other person involved in this because they don't know what the heck's going on. They really don't. It is very confusing for them. So, once we can explain these things; and they can understand them, so they can be an ally. They can very helpful in therapy. So, again, psychologically, there are behavioral things we can do, cognitive things, and intrapersonal things that might be helpful in this stabilization process.

Social Stabilization

With stabilization we want to decrease social alienation. As I've mentioned earlier, this is a time, for example, to increase the number of meetings; to increase the contact with a sponsor. Also, you might have someone who can get this through church, or through friends—a social network that is a healthy network. It can be there for them while they're going through this, especially in early recovery while they're dealing with some of these issues. We want to shore up everything, the alcohol/drug stuff, the self-help, and the sponsorship. We want to keep a focus on the alcohol and drug addiction. Never get away from that focus even when we're doing the crisis work here. We always have to remember that if we can't keep them clean and sober, we're not going to get this work done. So, we're going to have to do the things that help us here-- self-help, churches, support groups. There are a lot of support groups out there for people. If you have just about any problem in the world, you can find a support group for it, I think. So, ask around, call around. Look in the yellow pages. You might find a support group that can be helpful at this stage in the game. The ability to engage in competent social relationships is a very important prognostic variable. For example, if you have a client who is more of a wall flower, very introverted, and unfortunately a lot of your trauma survivors do score very high on introversion scales. They don't have much of a personality, they're not particularly pleasing in any way, this type of client is probably going to do worse than someone who is more extroverted, who is more outgoing, because self-help will work better for them. They like being around people. An introvert looks inside of themselves for what is going on. Maybe they're going to think it's a physical problem, or they look inside whereas the extrovert looks outside for help. So, the group, the self-help group, works very, very well for them. With your more introverted client, you might try having a couple of individual sessions before you put them into group. Just prepare them. They'll do much better with it. So, again, if we look at some prognostic variables, this ability to engage and to find good

relationships, to get the support they need, is a very powerful prognostic variable. We start to see positive outcomes.

Trust

So, we've talked about physiological, psychological, and social stabilization. Now let's look at this issue of trust. I use the word congruent. I use the word validate quite a bit. Let's just think for a minute about a client who is coming in, who is having PTSD symptoms or who has just had a traumatic episode (let's say they've been raped). They come into your office and they're angry, they're self-critical, they're depressed, and they're withdrawn. Let's just take self-critical. What if you had a client who was raped and they come into your office and they say this to you: "If only I hadn't of gone on that side of town, this would have never happened to me." What is that client saying to you? They're saying, "Yeah! My fault. I could have controlled this." Basically this is a control issue. You see, if one admits that they had no control at all over this—it could have happened anywhere at anytime—think of the vulnerability that comes along with that. That's just going to make things worse. So, like the Vietnam veteran with the guns, if I were to say—and I would say this from love—"Oh, don't beat yourself up! This could have happened to you anywhere, anytime. You know, where you were didn't make any difference at all." I might say that out of the goodness of my heart, but it's like pulling a rug out from under him. Here's a person whose personality is pretty fragile right now, and all I'm doing is I'm pulling out another means of their control because this is what they're doing. They're saying, "I had control over this. If I just didn't go to that part of town, it would have never happened." Now, in looking at this, we also want to enter their map of the world. The world is fundamentally changed for them. The world is unfair, but think of it in this way. For example, justice is a big deal for males, and trust is often very big in the female population generally speaking. A male who has been traumatized might say, "The world is a dangerous place." Now most of us would say, "The world is a place that has danger," but this trauma survivor has generalized it, globalized. "The world is a dangerous place." A lady might say, "The world is a place where you cannot trust anyone." Most of would say, "Yeah, there are people in this world that I can't trust. That's for sure. But there are a lot of people I can trust." This has been generalized. So, now, what are we asking them to do in early recovery? Let go, let God, and trust us. Now how big does that play? Then we say things to them like, "Work a selfish program." Now, that's a good deal if you know who you are, but when you don't even know who you are, how do you work a selfish program? There are certain things that happen in early recovery: I often think about these, things that are so simple like a nurse on a midnight shift walking into a room and shining that flashlight on someone who may have as a kid had visitation late at night in their room. We actually see these types of clients will wet the bed, defecate in the bed. They started doing it early in life. I'll see people do that even later in life because they did that as a defense strategy. "I'll make this bed really bad, and no one's going to want to get in here with me." They still may even do that later on. So, as we look at some of these things, this map of the world has changed. This map of the world has dramatically changed. So, they're not looking at it the same way we

are, and we've got to take that into account. Now, when we look at this, "The world is dangerous. When I let someone get close to me, I get hurt." When we look at this, the place that I would start is the therapist-client interaction—the development of rapport, of trust. Now, one of the things that I'm always aware of is that with people who have been hurt, they have grown up in a world where there was no responsibility regarding rules. The rules were broken on a day-to-day basis to meet the perpetrator's moment. Now, we're in a place where what we want to start to do is to give them some safety, to give them some limits. So, one of the things you'd never want to do with this type of client is make a contract with them that you cannot live up to. Don't put a rule in to play that you're not sure you can live up to. For example, don't say to them, "I'll see you in 30 minutes," because if it's an hour, basically they don't trust you. "Well, I knew I couldn't trust you." These are things they watch. These are important to them.

The Therapist

So, when I look at this from a therapist's perspective, I think a lot about being fair, consistent, and available. This is what a parent is. A parent is fair—these are the rules. A parent is consistent—we interpret the rules the same way every time—and a parent is available. So, when we start to look at this from a parental perspective, this is what we're doing. We're actually probably the first person, healthy person, that they are going to have a relationship with. More often not, their history has been one where every relationship they've been in has been chaotic--where the rules have changed and shifted. They could not count on anything to be consistent. So, all of a sudden, the first thing we have to be is that for them. In other words, you're mothering them, you're fathering them. You're their parent right now. These are the rules. They're very simple. I like to make rules so simple that even staff can understand them. When you have a 20-page patient handbook that the staff has never read, especially the adolescents are just going to beat you to death with it. They're going to have staff bouncing all over the place with this stuff. Make the rules real simple. I used to run alcohol and drug programs on three rules: 1) No sex. 2) No fighting. 3) No alcohol or drugs on the unit. If you couldn't honor these rules, it means that we wouldn't kick you out: it meant you need a more restrictive level of care. Maybe you need to go to the psych unit for awhile. So, this ability to set limits is very important because if this client gets angry, and you come back in an authoritarian way, in other words, you get too strict and you say, "You better cut that out or we're going to kick you out of here!" basically what they internalize is that you're just another perpetrator out to get them. On the other hand, we have many staff who have unresolved needs; so do these types of clients. These are the ones who we put our arms around and we say, "Oh, I understand. You violated every rule in the rule book, but I understand. I come from where you do, and I'm going to let you get away with all these rules violations. Let's keep it our little secret" and you're basically impotent. So, when we start to look at it in this way, it's the ability to set the limits and be consistent that is going to be most important in developing this rapport. That patient has to be able to count on you now. If they cannot, we're not going to get to a point where we're going to deal with these issues.

Now, trust, as I have mentioned, has a lot to do with their past experience with the rules. Power issues in therapeutic relationships are very interesting. I had a 35-year-old female, her name was Maria, and she was a very successful business person. She was vice president of a very large corporation. But it is very interesting to think about her because she came in, and the reason she came to see me was because she was very frightened that she would not be promoted because she seemed to have some difficulty with a lot of the men in the company who were her supervisors or higher ups. She was certain that this relational problem was going to keep her from achieving her business goal. So, she came in to see me, and she was pretty upset about it. In the first two sessions, I was very directive. I started to talk to her about things to do, to stay out of, ways to keep herself safe, buying a little time so we could really start to look at this stuff, and that worked well. She responded beautifully to it. She was doing better at work. The third session was at 9 o'clock on a Friday night. I was a little tired. I walked in, and I looked at her and I said, "What would you like to talk about tonight?" I went from very directive to very non-directive. What she did was jumped out of her chair, looked at me, and said, "You're not listening to me," and left the room. It freaked me out. I mean, I didn't know what was going on. I called her up later that night, and I wanted her to come back. Somehow it seemed important for me, and maybe important for her I hope, but I wanted to know what was going on. We started to work together, and it was very interesting because in about 3 months, we were looking at early life issues, trauma issues, the stuff that happened in her home. What she said to me once was, "In my home, my father used to do things to me. I used to go and tell my mother what my dad was doing, and my mother would look at me and she'd say, 'No, that could never happen in our family.'" And she looked at me and said, "My mother never listened to me." Now we know where it comes from. It's power. In a therapeutic relationship, you can assume all sorts of positions; and if you knowingly do it with certain clients, you can evoke a lot of different responses. It is very good clinically. But in this situation, I came in and I was Dad. I had the power the first two sessions to be very directive, do this, do that. In that third session, I moved over to less power; and that was Mom. That's where her anger was directed at, at her mother who never listened to her, who never helped her. When I moved into that position, she jumped right out of the chair. "You never listen to me!" These are things that can happen sometimes. So, in looking at an issue with this, we can see where this stuff is obviously going to get in the way. So, again, trust is a fragile thing. They're going to feel you. These people are very sensitive. Alcoholics and addicts are sensitive. When you get people who are trauma survivors on top of that, you've got people who are sensitive to every little nuance. Unfortunately, they misread some of them. They make problems where problems don't exist.

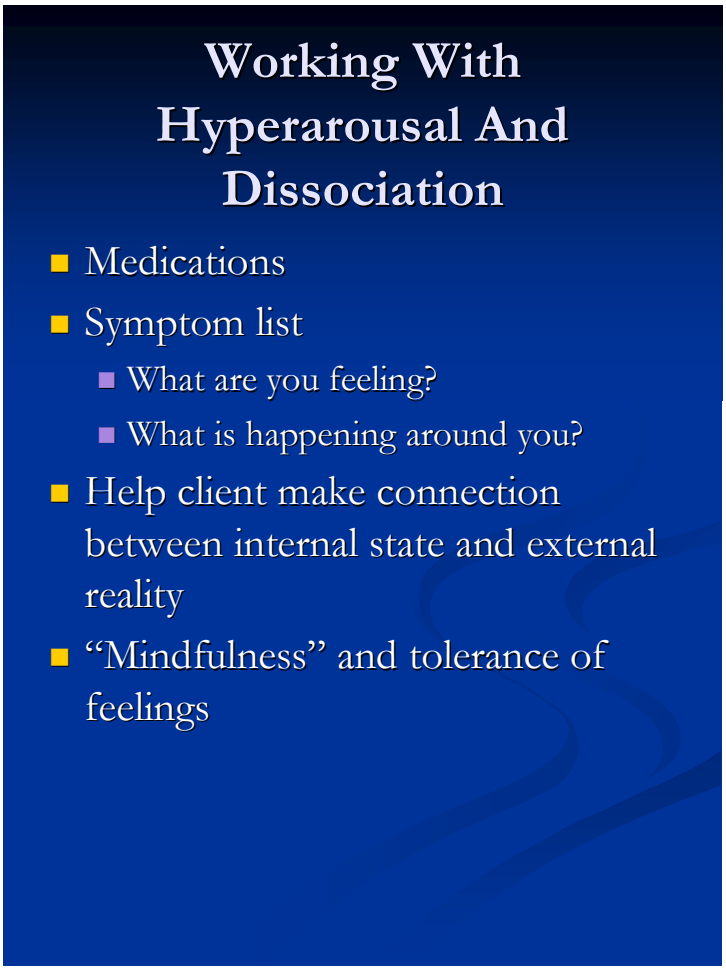
Safety

So, as we look at this a little and move on, the first thing we always remember is safety. We're going to give this person a chance to be a child. What's so wonderful about doing this type of work is that when you lead someone through it;

and they go through it, and they do the work, they actually take on almost childish or adolescent… There's a piece to them that comes alive. That's very wonderful to watch. To me it's always about that little baby. Giving that little kid a chance to come out and play a little bit. It doesn't always have to be so uptight and so controlling and so dangerous. It doesn't have to be so depressing and so bad all the time. We can actually let them be like kids. They can learn to do that. But above all else, make sure that we do no harm. Always it has to come from the clients. They have to tell us the story. We can't put in their mouth, and we don't want to misread a few symptoms and tell them they're trauma survivors and they can't remember it, or whatever. So, in looking at this, safety is first. Now, if we're working with numbing and hyperarousal-- we talked about this a lot. The person is doing pretty well-- they've got the good cognitive-behavioral stuff, and all of a sudden something happens. It could be any sense—smell, seeing somebody, hearing something, it could be a song—all of a sudden they hyperarouse or numb off. We talked about at that stage that they're dissociating or hyperarousing, and they're going back. They're actually going back to some little safe little place, or they're hyperarousing and getting ready to fight. So, we know that when they do this, they have certain things that they will do over and over again. One of the things is, they'll run back to the therapist. If that doesn't work, they'll run into a relationship. Next thing they'll often do is use alcohol, drugs, food, sexual behavior for relief. If that doesn't work, then we start to see the suicidal/parasuicidal types of problems that we talked about.

Now, if we looked at working with this hyperarousal and dissociation, sometimes medication, as we talked about, can be helpful. Depending upon the severity and, by that, what problems is it causing them? It is causing them problems at work? Is it causing problems in the family and their relationship? If it is severe enough, a medication is the way to go. What I might ask them to do is to make a symptom list. "What I want you to do is just make a symptom list. Every time you start to feel something, a symptom, you've got a little problem with your stomach or you're starting to hear yourself say things or you start to feel a different way or you're tempted to use alcohol and drugs, write it down. Write down all of these symptoms. And then what I want you to do is to write down where you are, who you're with, what time of day it is." Now, I want them to tell me everything that's happening around them. "What are you feeling and what's happening around you?" Now, when a client comes in, what we're trying to do here is help them understand that the feelings they're having on the inside are related to things that are going on around them. That's the connection they're not making. They're not making this connection. In its purest sense, this is almost alexithymia—the inability to give words to emotions. "I'm feeling bad because someone is giving me a hard time, or I'm in a difficult situation or I'm having a problem at work." They don't seem to be able to do that very well. So, what we're trying to do here is we're trying to help this client make connections between these internal states and what's going on around them. When they start to make that connection, we teach them to become more mindful; to start to understand and monitor themselves a little better. When they're feeling and trying to look around and understand what's happening around them, ask what's going on in your life right now that might make you feel this way? In the

past, these symptoms would come up, and I don't know where they came from. All of a sudden, I'm feeling this, I'm doing that. But now at least we're giving them a connection to something more real, a little more reality. The mindfulness and tolerance of feelings will help them deal a little more effectively with these situations. If we can reduce that hyperarousal and that dissociation, they're going to be able to continue to do those things they're doing in recovery to keep them straight and sober. Now, there are other ways to reduce the hyperarousal, but let's think about, just for a few minutes, if we were going into the literature and we were going to ask a question. We're going into a search engine, and we're going to ask a question. What is the most effective therapy for people who have the symptoms we have talked about, who have a history of PTSD or early life problems, complex PTSD? We looked at the literature and we read it thoroughly; what we would find is that there is only one. It has absolutely been proven to be effective with this population. It's called behavioral exposure therapy. It involves imaginal exposure and in vivo exposure. I'm going to take you back to Peggy. Remember I talked about Peggy? The one that kind of hit the guy in the movie theater in the nose? Peggy is very interesting. In working with her, I took her through a particular technique that was the imaginal part of this. I asked her—this was on an outpatient basis—"On Tuesday between 7 and 8 or whatever time you want to allocate; I want you to sit down with a piece of paper and a pen, and I want you to write a letter to the perpetrator." Now, I'm not doing anything too cathartic or too abreactive here. They can do it at their own pace. It's pretty effective in early recovery. I'm not trying to bang them too hard. They can back away from it, and they're going to have help if they need it. So, what I tell them is, "Between 7 and 8 on Tuesday night, sit down and write this letter. In the letter, what do you remember, how has it affected your life, and how do you feel about it today." Now, you can add whatever you want to that letter, but those are three pretty good things to put in there. Tell them that when they do that between 7 and 8, if things get too heavy, if they start to have a lot of problems, that I will be in the clinic. I will be available. Now, when they call they may get an answering service, they may not get directly to me—and I have to tell



them this—but I tell them this, "Before the evening is over, I will get back to you. You already have a few strategies that can help you get through this, so use those things that we've already taught you—the safety plan, the other stuff—and I'll get back to you." I can't say, "I'll get back to you in 30 minutes," because if I miss, I create a problem. So, I usually try to get back as quick as I can, and we talk through it and kind of stabilize the situation. But generally, they write this down and they come to a session, maybe 9 o'clock the next morning, and I ask them to read the letter to me. As they read the letter, sometimes they get angry, sometimes they cry. About the worst thing I've had is one kicked a chair. It's really emotional because they're dredging up a lot of old stuff. When they finish, I say, "I just want to congratulate you. What you did was a very brave thing, and you should be very proud of yourself because you've shown great courage in doing this. But I just want to tell you that there are some other things that you're remembering that aren't in this first letter. So, I want you to go back on Thursday evening," and I try to put the appointments as close together as I can, "between 7 and 8," and we go through the same thing. "You have access to me if you need it. I want you to re-write the letter, remembering those things you're going to remember," which is almost, if you think about it, sort of a presupposition or almost a suggestion. They come back this time, and they read it to me and with often a little less emotion. About 3 or 4 times, no

more than 5 times, I'll generally have a person—the ones that will go through this, and most of them will (I've done this a lot)—who will read the letter to me just like they're reading the newspaper. No emotion at all. When you have done that, you have knocked out the hyperarousal and a lot of the constrictive symptoms and a lot of the numbing off—the intrusive symptoms. You still may have some of the constrictive symptoms there, but what you've done is you've knocked off that top and bottom. We talked about one way to do it in terms of the symptom list and trying to help them understand what's happening inside and how it relates to what's going on around them. In this particular way, what we're talking about is helping them get through this using a role play or a personal exercise where they go in, they write, and they're doing this exercise. They come in and after they do it so many times, it's gone. Now, this is really interesting because Peggy, about three weeks after we did this, got a letter from her brother. Her brother was the perpetrator. It was a wedding announcement. She hadn't seen her brother in probably 10 years. Every time she had been around her brother in the past, she had the experience of fear and anger—sort of gripped with the fear and anger of him. It was that same piece that hit that fellow in the nose in that movie theater because when that happened, she was 7, 6, 8. She wasn't 29 or 35. So, what happened is that she had this invitation. We talked about it, and we decided that she should go. This was basically the in vivo exposure, if you will. So, what she did, she went to the wedding, and she came back and she walked in the office. The first thing she said to me was this, "It's the first time I could ever remember being in a room with my brother and really wishing him well and caring for him." What a different reaction, huh? What we knocked out was all that stuff. Right now, she is seeing things through the eyes of an adult. She's not seeing them through the eyes of a 7-year-old. She is here. She's not there anymore. So, what we anticipate in her recovery when she runs into these situations that she should be able to look at these things much more subjectively now. This is going to be very helpful. Now, one of the things we've got to remember is this doesn't mean they know how to have a relationship; they know how to solve problems. There's a lot more work to be done here regarding relationships and solving problems. A lot of good group work can be done with that. But when you start to look at something like this; this is, to me, a much safer way of going about it than trying to do some abreactive cathartic process. What really irritates me is when I see people on TV or other places who just open all this stuff up in a weekend or do something on TV and walk away. That to me is malpractice because when a person goes through some of those trauma weekends, they walk out feeling wonderful, light, and free—and that's nice. The problem with that is, it only lasts for a day or two because it kicks them into depression, which is part of the last piece of going through the grief process. You've got to move them through that depression. I don't want to have that person out there that depressed, potentially suicidal, because of something I did and opened up over a weekend. You only do this when you have follow-up. So, I don't think it can be done on TV very well.

Virtual Reality

Let me also tell you that there is some interesting stuff out now that the VA system and a few others are using around virtual reality with some of the soldiers. They're virtually re-creating the traumatic scene and taking them through it as a way of behavioral exposure. Some of you are probably saying, "Well, eye movement desensitization seems to work well for some of these people." Eye movement desensitization has as its core behavioral extinction. I don't know about the finger stuff, but there is behavioral extinction at the core of what they do. So, there are other therapies that use behavioral extinction that have various names, but when you start to look at the data, these are the ones that have been proven successful. Now, I think in looking at this type of exposure, we would generally combine it with relaxation training. Maybe controlled breathing, muscle relaxation, maybe a little psychoeducation, cognitive restructuring, trying to help them out with some of these old issues that are still getting in their way of getting what they want in life. So, just because we do this doesn't mean we have a perfectly happy camper who can solve all of life's difficulties. We still have a long way to go, but they have a shot now. They have a better shot at recovery; and they have a better shot of learning to be more child like, more adolescent. It kind of kicks them into a really interesting place. Some clients I have actually recommended to them to go and sit with their friend's children and spend time with their friend's children making plastic cheeseburgers because nobody can teach you how to be a child like a child can. These people will go, and they don't even pay attention to their friends anymore. They sit on the floor playing with these kids, having the best time in their life making cheeseburgers in ovens and doing this stuff and throwing a little baseball, and that's now one new part of them. It's almost like a way that they're starting to get a little bit of it back. To me, that's a wonderful thing.

The Future

Now, they start to look at that trauma treatment in early recovery. There has been the historical injunction, but there are several preliminary studies that have shown that treating PTSD in early recovery works very well. Actually, there is a recent study with cocaine addicts. So, when we start to look at this, these are all relapse symptoms we're talking about, so if nothing else, we treat it as a relapse piece. Early life trauma clients often struggle in self-help groups. They don't know who to choose as a sponsor; how to pick a good meeting. "Just trust, let go, let God. You don't have control of anything. Let it go. You're powerless. " These are things that go against their grain because they're trying so hard to maintain control. So, I think in looking at what we've tried to do in talking about these particular problems is to talk about the fact that the effects of trauma are extremely far reaching; and every area of their being is affected by this including the areas of their brain psychologically, cognitively, socially. All of these things were affected. Many of them have alcohol and drug problems. These people are chronic recidivists. The relapse issue often is the trauma-related issue around relationships and anger and other things. So I think it is incumbent upon us to take a serious look at what we can do to help these people in their recovery in helping them have a much better life than what they're having currently. I know that for some people in the addictions field, treating trauma in early recovery is uncomfortable. It's not what you've been taught. You've been taught just the opposite, but I'd like for you to keep an open mind. We have a field that is full of hardening of the categories in psychosclerosis. We're very slow in changing sometimes; but if we stay client focused, and we look at the problem; we look at the pain and the relapse issue; I think that this stuff can actually work. We can do it, and we can do it relatively safely. It is very important that you are comfortable doing this work. You don't have to do it yourself. You can know somebody else who does it. You can refer them. It is wonderful work, and you'll see some things that will happen that will just lighten up your soul. These are marvelous people. They really want help, and they come back over and over and over looking for it. Instead of seeing that as something as negative, see it as flattering because they really believe that you've got something that can help them. So, I think that the bottom line here is let's just keep an open mind. Let's try to learn more and more about this. Let's try to look at our agencies of treatment and see if we can start to do some things that would be helpful to this relapse population. I think in the end we're going to see some of that chronic recidivism knocked down, and we're going to see a lot of people with a much happier recovery.

Trauma Treatment In Early Recovery

- Historical injunction
- Several preliminary studies have shown success in treating PTSD in early recovery
- PTSD and related symptoms (depression, insomnia, etc.) are relapse symptoms
- Early life trauma clients often struggle in self help groups

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Appendix A: Post Test and Evaluation for *Treating Early Life Trauma Related Issues in Early Recovery*

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Answer the following questions by selecting the most appropriate response.

1. People with early life trauma history comprise what portion of treatment program recidivists?
   a. 1/5 to 2/5
   b. 2/3 to ¾
   c. ¼ to ½
   d. 75%
   e. 25%

2. People who come into treatment 10 to 15 times or more have relapse issues that are the:
   a. New stuff
   b. Chemical stuff
   c. Nuff stuff
   d. Buried stuff
   e. Old stuff

3. Which of the following could be equally as devastating for a child as physical or sexual abuse?
   a. Hexes
   b. Birth order
   c. Negativism
   d. Neglect
   e. Mixed race parents

4. People who have been traumatized generally come in to treatment with feelings of:
   a. Self-blame
   b. Being damaged
   c. Emptiness
   d. Poor impulse control
   e. All of the above

5. People with a trauma history have a higher incidence of:
   a. DTs
   b. Psychosis
   c. Mental retardation
   d. Multiple psychiatric disorders
   e. Single psychiatric disorders

6. The most desirable drug for people who have trauma history is:
   a. Nicotine
   b. Opiates
   c. Alcohol
   d. Cocaine
   e. Cannabis

7. The brain develops from_____and_____.
   a. Left side, right side
   b. Bottom up, outside in
   c. Bottom up, inside out
   d. Top down, inside out
   e. Top down, outside in

8. Another word for dissociation is:
   a. Semi-association
   b. Pseudo-association
   c. Space out
   d. Numbing off
   e. Dumb out

9. An addicted person should be at least one year clean and sober before they begin to work on traumatic early life issues.
   a. True
   b. False

10. What percent of women with irritable bowel syndrome were trauma survivors?
    a. 60
    b. 40
    c. 30
    d. 20
    e. 80

11. The most common outcome of trauma is depression and:
    a. ODPT
    b. OCD
    c. Level 2 stress
    d. DSM-IV
    e. PTSD

12. High enough cortisol levels in someone can mimic symptoms of:
    a. SIDS
    b. AIDS
    c. OCD
    d. ODTP
    e. Level 2 stress

13. The main survival defense mechanism(s) are:
    a. Freeze
    b. Fight
    c. Flight
    d. Dissociation
    e. All of the above

14. The relation between trauma and physiological changes is seen more often in:
    a. Journal content
    b. Dream content
    c. Introverts
    d. Extroverts
    e. First born children

15. Alcoholics and addicts have difficulty integrating_____and_____.
    a. Feelings, thoughts
    b. Good feelings, bad feelings
    c. Internal reality, external reality
    d. Perceptions, reality
    e. Facts, feelings

16. People who are traumatized are very:
    a. Hypoaroused
    b. Perceptually narrow
    c. Compartmentalized
    d. Hypnotizable
    e. Introspective

17. Abandonment fear leads to:
    a. Increased impulsivity
    b. Acting out
    c. Drinking
    d. Drugging
    e. All of the above

18. The correlation between early life trauma and borderline personality disorder is:
    a. 20%
    b. 80%
    c. 50%
    d. 33%
    e. None of the above

19. People who have suffered early trauma have an ultimate need for:
    a. Cognitive clarity
    b. Control
    c. Affective clarity
    d. Sensation seeking
    e. Introspection

20. The hippocampus is responsible for:
    a. Fear
    b. Fight
    c. Flight
    d. Creativity
    e. Memories

21. Being hurt at the hands of those who should love and care for you is called:
    a. Primary trauma
    b. Secondary trauma
    c. Sanctuary trauma
    d. Genetic trauma
    e. Intergenerational trauma

22. Research seems to be telling us that trauma is:
    a. Left-brain oriented
    b. Right-left brain transposed
    c. Right-brain oriented
    d. Mid-brain oriented
    e. Total brain oriented

23. There are drugs for treating trauma.
    a. True
    b. False

24. Early life trauma clients often struggle in self help groups.
    a. True
    b. False

25. Virtual Reality Therapy is being used to treat:
    a. Brain damage
    b. PTSD
    c. SSTD
    d. ADHD
    e. Sensation seeking

26. The leading cause of PTSD in the USA is:
    a. Alcohol and drug addiction
    b. Combat related issues
    c. Job stress
    d. Auto accidents
    e. Spousal abuse

27. The most common outcome of trauma is:
    a. Irritability and migraine headaches
    b. Anger and resentment
    c. Insomnia and other sleep disorders
    d. Marriage and job problems
    e. Depression and PTSD

28. Dissociative symptoms are found in females very early in life.
    a. True
    b. False

29. The percentage of trauma survivors who re-victimize their own kids and other is about
    a. 10%
    b. 20%
    c. 40%
    d. 50%
    e. 60%

30. The area of the brain that has to do with fear response is:
    a. Hippocampus
    b. Amygdala
    c. Corpus callosum
    d. Temporal lobe
    e. Prefrontal cortex

31. The medication that improves the memory and concentration of PTSD patients is:
    a. Valium
    b. Baclofen and Depakote
    c. Lithium and Tegratol
    d. Clonidine and Inderal
    e. Zoloft and Paxil

32. The most effective therapy for clients who have a history of PTSD, early life or complex PTSD is:
    a. Self help groups
    b. Psychiatric sessions
    c. In-patient treatment
    d. Behavioral exposure therapy
    e. Modern Aversion Therapy

33. Introverted clients do well in individual sessions, rather than self help groups.
    a. True
    b. False

34. Cortisol is:
    a. A prescription antidepressant drug
    b. An over the counter sleep aid
    c. An illegal narcotic
    d. A stress chemical produced by the body
    e. A harmless drug produced in the liver.

35. In situations where couples are involved in therapy it is helpful to:
    a. Separate the couple during the therapy so that they feel free to individually share everything with the therapist.
    b. Have the client and her partner write individual descriptions of the problem; each expressing his/her own view.
    c. Provide the spouse / partner of the client with a list of do's and don'ts.
    d. Have the client and the spouse / partner participate in the therapy sessions together.

The final step in the process required to obtain your course certificate is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. **If you submit your evaluation online, you do not need to return this form.**

NAME:_____

COURSE TITLE: Treating Early Life Trauma Issues in Early Recovery From Addictive Disorders

DATE:_____

COURSE CONTENT		
Information presented met the goals and objectives stated for this course	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was relevant	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

_____

COURSE MECHANICS		
Course materials were well organized	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Materials were received in a timely manner	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Cost of course was reasonable	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
OVERALL RATING		
I give this distance learning course an overall rating of:	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
FEEDBACK		
How did you hear about CEU Matrix?	☐ Web Search Engine ☐ Mailing ☐ Telephone Contact ☐ E-mail posting ☐ Other Linkage ☐ FMS Advertisement ☐ Other: _____	
What I liked BEST about this course:		
I would suggest the following IMPROVEMENTS:		
Please tell us how long it took you to complete the course, post-test and evaluation:	_____ minutes were spent on this course.	
Other COMMENTS:		