

AN INTEGRATED APPROACH TO TRAUMA, BORDERLINE PERSONALITY DISORDER AND ADDICTION

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SOME CORE COMPETENCIES FOR STAFF WORKING WITH CO-MORBID TRAUMA, BPD AND ADDICTION

- Recognize that addiction is a **disease**
- Understand the neurobiology of stress and addiction
- Be aware that these disorders do not co-occur; they **interact**. All elements of a treatment program should be based on this awareness
- Be familiar with the co-morbidity of trauma and addiction
- Know the difference between single event, acute trauma and early-onset, chronic trauma
- Understand trauma-informed approaches
- Be trained in Motivational Enhancement Techniques
- Conduct phase-oriented treatment
- Respect the philosophy and nature of 12 step programs

ADDICTION IS A DISEASE

Disease is defined as “any deviation from or interruption of the normal structure or function of any part, organ, or system (or combination) of the body that is manifested by a characteristic set of symptoms and signs, and whose etiology, pathology, and prognosis may be known or unknown.” *Dorlands Illustrated Medical Dictionary, Twenty-Seventh Edition*. Philadelphia: Saunders, 1988.

SIMILARITIES AMONG TRAUMA, BPD AND ADDICTION

Client Deficits

Problems with affect regulation
Problems with self-care
Cognitive distortions
Altered emotionality (depression/anxiety)
Disturbed interpersonal relations
Avoidance
Poor self-efficacy
Low self-esteem
Disrupted neurobiological processes

SIMILARITIES AMONG TRAUMA, BPD AND ADDICTION (continued)

Therapeutic Approaches

Validation/empathy
 Understanding of symptom functions
 Increase awareness
 Addressing “resistance” and denial
 Sequencing of goals/hierarchy of treatment targets

ATTACHMENT AND THE DEVELOPING BRAIN

“The brain’s development is an ‘experience-dependent’ process, in which experience activates certain pathways in the brain, strengthening existing connections and creating new ones . . . Early in life, interpersonal relationships are a primary source of the experience that shapes how genes express themselves within the brain” (Siegel, 1999, p 13-14).

ATTACHMENT AND THE DEVELOPING BRAIN (continued)



The next five slides are based on the work of Alan Schore

- The brain’s structure and function are shaped by interpersonal experience
- The self-organization of the developing brain occurs in the context of a relationship with another brain (human connection creates neuronal connections)
- The other brain (the primary caregiver) acts as an external regulator of the infant’s nervous system
- The developing mind (the infant’s) uses the states of the caregiver to help organize the formation of its own states
- The right hemisphere is dominant in human infants and is involved in the reception and expression of affective states

ATTACHMENT AND THE DEVELOPING BRAIN (continued)

- The primary caregiver regulates arousal states in the infant through right hemisphere to right hemisphere interaction
- While experience may alter and change the functioning of an adult, experience literally provides the organizing framework for an infant and child
- The more a certain neural system is activated, the more it will “build-in” this neural state: what occurs in this process is the creation of an “internal representation” of the experience corresponding to the neural activation (the brain is designed to change in response to repetitive stimulation)
- The primary caregiver should maximize positive affect states and minimize negative states in the infant

ATTACHMENT AND THE DEVELOPING BRAIN (continued)

- Children reflect the world in which they are raised. If that world is characterized by threat, chaos, unpredictability, fear and trauma, the brain will reflect that by altering the development of the neural systems involved in the stress and fear response
- The brains of traumatized children are in a state of fear-related activation
- A traumatized child may exhibit motor hyperactivity, anxiety, depression, behavioral impulsivity, attention deficits, sleep problems, tachycardia and hypertension

THE HIERARCHICAL SYSTEM OF THE DEVELOPING BRAIN

“Bottom-Up” versus “Top-Down” functioning

- The amygdala, anterior cingulate and orbitofrontal cortex make up a three-tiered hierarchical system of the brain
- The amygdala is the deepest unconscious level; the orbitofrontal cortex is the highest conscious level
- The amygdala appraises information about external stimuli and modulates arousal systems
- The amygdala undergoes a critical period of maturation from the last trimester of pregnancy through the first two months of life
- At birth, only the amygdala is on line

THE HIERARCHICAL SYSTEM OF THE DEVELOPING BRAIN (continued)

- From the last quarter of the first year through the middle of the second year, the prefrontal cortex enters a critical growth period
- The later developing cortical levels (e.g., orbitofrontal cortex) regulate the earlier developing subcortical levels (e.g., amygdala) in a hierarchical fashion
- Secure attachment relationships facilitate the experience-dependent maturation of this hierarchical system
- Early trauma interferes with this maturation
- During future stress the connections between the subsystems will dissociate from each other, that is, amygdala activity would be unmodulated by the orbitofrontal level and may predispose the individual to PTSD

AAI CLASSIFICATIONS AND CORRESPONDING PATTERNS OF INFANT STRANGE SITUATION BEHAVIOR

- The Minnesota Longitudinal Study studied high risk mothers (e.g., very young, or involved in domestic abuse, drugs, or prostitution) and their infants for more than 30 years with multimethod assessment instruments at every phase of development from infancy.
- Attachment status was assessed with the Strange Situation paradigm and with the Adult Attachment Interview (AAI).

AAI CLASSIFICATIONS AND CORRESPONDING PATTERNS OF INFANT STRANGE SITUATION BEHAVIOR (continued)

Adult State Mind Re Attachment Secure/autonomous

Coherent, collaborative discourse. Valuing of attachment, but seems objective regarding any particular event/relationship. Description and evaluation of attachment-related experiences is consistent, whether experiences are favorable or unfavorable.

Infant Strange Situation Beh Secure

Explores room and toys with interest during pre-separation episodes. Shows signs of missing parent during separation, often crying by the second separation. Obvious preference for parent over stranger. Greets parent actively, usually initiating physical contact.

AAI CLASSIFICATIONS AND CORRESPONDING PATTERNS OF INFANT STRANGE SITUATION BEHAVIOR (continued)

Adult State Mind Re Attachment Dismissing

Not coherent. Dismissing of attachment-related experiences and relationships. Normalizing (“excellent, very normal mother”), with generalized representations of history unsupported or actively contradicted by episodes recounted.

Infant Strange Situation Beh Avoidant

Fails to cry on separation from parent. Actively avoids and ignores parent on reunion (i.e., by moving away, turning away, or leaning out of arms when picked up). Little or no proximity or contact seeking, no distress, and no anger. Response to parent appears unemotional. Focuses on toys or environment.

AAI CLASSIFICATIONS AND CORRESPONDING PATTERNS OF INFANT STRANGE SITUATION BEHAVIOR (continued)

Adult State Mind Re Attachment Preoccupied

Not coherent. Preoccupied with or by past attachment relationships/experiences, speaker appears angry, passive, or fearful. Sentences often long, grammatically entangled, or filled with vague usages. Transcripts often excessively long.

Infant Strange Situation Beh Resistant or ambivalent

May be wary or distressed even prior to separation, with little exploration. Preoccupied with parent throughout procedure, may seem angry or passive. Fails to settle and and take comfort in parent on reunion, and usually continues to focus on parent and cry. Fails to return to exploration after reunion.

AAI CLASSIFICATIONS AND CORRESPONDING PATTERNS OF INFANT STRANGE SITUATION BEHAVIOR (continued)

Adult State Mind Re Attachment Unresolved/disorganized

During discussions of loss or abuse, individual shows striking lapse in the monitoring of reasoning or discourse. For example, individual may briefly indicate a belief that a dead person is still alive in the physical sense, or that this person was killed by a childhood thought. Individual may lapse into prolonged silence.

Infant Strange Situation Beh Disorganized/disoriented

The infant displays disorganized and/or disoriented behaviors in the parent’s presence, suggesting a temporary collapse of behavioral strategies. For example, the infant may freeze with a trance-like expression, hands in air; may rise at parent’s entrance, then fall prone and huddled on the floor or may cling while crying hard and lean away averting gaze.

NEUROANATOMY AND STRESS

The Amygdala

- Environmental information is transmitted through the thalamus to sensory cortical receiving areas and from there to the amygdala
- The amygdala assigns meaning to sensory information and guides emotional behaviors by projections to the hypothalamus, hippocampus and basal forebrain
- The “hot” amygdala reacts to fearful events in an unintegrated fragmentary manner (emotional, quick, direct) and provokes a sense of reliving the event

NEUROANATOMY AND STRESS (continued)

The Hippocampus

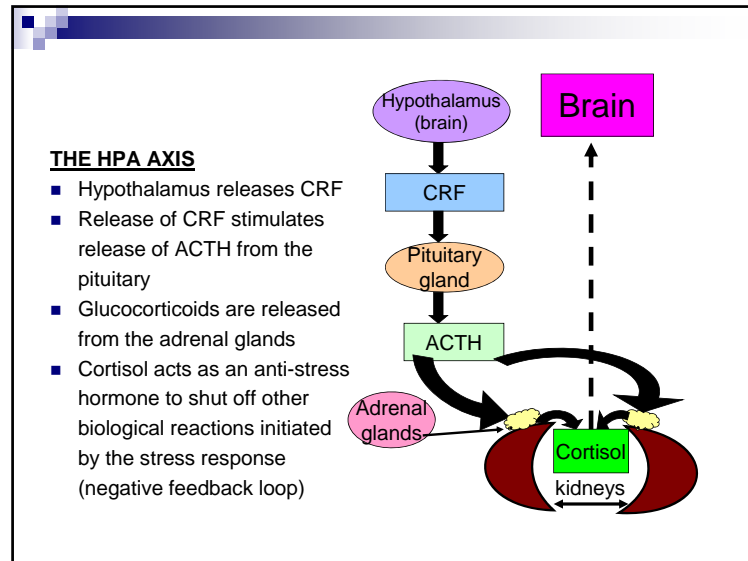
- The “cool” hippocampus unemotionally records autobiographical events in spatial-temporal context.
- This system is integrated, cognitive, complex and neutral.
- The individual knows that the events occurred in the past and does not mistake the memory as a current event.
- The hippocampus is a major target organ for stress hormones (glucocorticoids).
- Research indicates that hippocampal damage is associated with direct exposure of glucocorticoids to the hippocampus.
- Studies have indicated that individuals with trauma have decreased hippocampal volume.

NEUROANATOMY AND STRESS (continued)

- Encoding in these two systems (the amygdala and the hippocampus) operates in parallel
- The “hot” system (the amygdala) encodes the fear-provoking aspects of the experience while the “cool” system (the hippocampus) encodes context.
- At low levels of stress, there is an increase in hippocampal responsiveness
- At higher levels of stress the hippocampus becomes less responsive

NEUROANATOMY AND STRESS (continued)

- At extremely high levels of stress, the hippocampus becomes dysfunctional while the amygdala becomes hyper-responsive
- As a result encoding under high levels of stress is likely to be fragmentary rather than spatial-temporal
- The individual may focus exclusively on the fear-evoking features of the event
- This may explain the irrational fears, fragmented memories, and dissociated experiences in individuals with chronic trauma



NEUROANATOMY AND STRESS (continued)



The Hypothalamic-Pituitary-Adrenal (HPA) Axis

- Perception of stress results in release of corticotropin releasing hormone (CRH) from the hypothalamus into the pituitary portal circulation
- In turn, adrenocorticotrophic hormone (ACTH) is released from the pituitary gland
- ACTH initiates the release of the adrenal androgens and glucocorticoids
- Glucocorticoids prepare the body for stress by, for example, increasing glucose

NEUROANATOMY AND STRESS (continued)

The Hypothalamic-Pituitary-Adrenal (HPA) Axis (continued)

- Glucocorticoids bind to glucocorticoid receptors in the pituitary, hypothalamus and hippocampus which inhibits the synthesis and release of CRH and ACTH (a negative feedback loop)
- CRF has been implicated in the pathophysiology of anxiety, affective, and addictive disorders.
- Drugs of abuse activate the CRF/HPA Axis during use/abuse, and alterations in the CRF/HPA and noradrenergic systems during acute withdrawal/abstinence are also well documented

NEUROANATOMY AND STRESS (continued)

Pathophysiology of the HPA Axis in PTSD

- An adaptive response to stress should be rapid and limited
- Excessive HPA response is maladaptive
- Individuals with PTSD show an increase of CRF secretion from the hypothalamus
- The pituitary gland releases significantly more ACTH in individuals with PTSD
- These neurobiological differences suggest a sensitization of the HPA axis in PTSD

NEUROANATOMY AND STRESS (continued)

Pathophysiology of the HPA Axis in PTSD

- This means that individuals with PTSD are more sensitive to stress rather than less sensitive
- This sensitization of the HPA Axis in patients with PTSD has serious implications for therapeutic interventions.
- Interventions such as exposure techniques (e.g., “prolonged exposure” or “in vivo desensitization”) should not be utilized until the patient is sufficiently stabilized.

NEUROBIOLOGY OF ADDICTIVE DRUGS

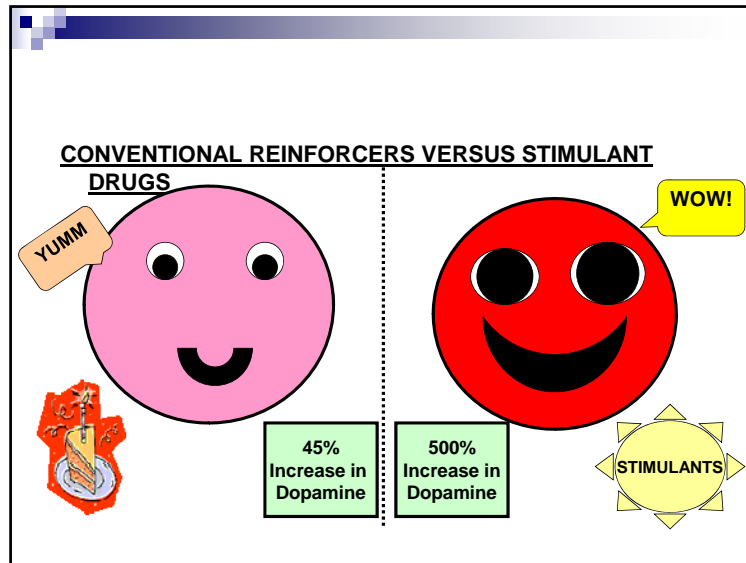
- Drugs of abuse change the brain
- These changes include alterations at the structural, functional, cellular and neuronal level as well as gene expression
- These changes in the brain are exhibited in the affective states and the behavior of the individual taking the drugs
- These changes persist for varying lengths of time even when the individual becomes clean and sober
- Some of these changes may be permanent
- These changes in the brain increase the vulnerability of the individual to relapse even after long periods of abstinence

NEUROBIOLOGY OF ADDICTIVE DRUGS (continued)

Substance dependence is the result of a complex interaction of the physiological effects of drugs on brain areas associated with motivation and emotion, combined with “learning” about the relationship between drugs and drug-related cues, all of which have a biological base.

NEUROBIOLOGY OF ADDICTIVE DRUGS (continued)

Dependence-producing drugs differ from conventional reinforcers in that their stimulant effects on dopamine release in the nucleus accumbens are significantly greater than natural reinforcers such as food.



METHAMPHETAMINE (MA) AND THE BRAIN

- Activation of reward and affect-related neural circuitry is the basis for the positive subjective responses to MA.
- Early abstinence is associated with limbic hyperreactivity and a syndrome that consists of depressive and anhedonic states, anxiety, drug-craving, impulsivity and cognitive impairment.
- Even after the acute abstinence syndrome resolves, cognitive, affective, and regional brain deficits persists.

METHAMPHETAMINE (MA) AND THE BRAIN

- Neuroimaging evidence points to prefrontal cortex deficits, in particular in relation with the dopaminergic system, as underlying the cognitive deficits, compulsive behaviors, impulsivity, and poor decision making often exhibited long after abstinence from MA.
- Similarly, the serotonin system remains impaired and can underlie some of the dysregulated affective responses, such as aggression and residual psychotic symptoms.
- The implication is that there may be a temporal mismatch between the learning expected of the patient during therapy and his or her ability to process and retain the new material that constitutes the therapeutic approach.

*“Drugs kept me alive
until I was ready to live”*

Client with heroin addiction and trauma

PTSD AND SUBSTANCE USE DISORDERS

- PTSD and substance use disorders have a number of connecting pathways.
- Substance intoxication may heighten the likelihood of exposure to trauma, hence the likelihood of developing PTSD.
- Chronic substance use and withdrawal may increase anxiety/arousal states, making it more likely that individuals with substance use disorders will develop PTSD after trauma exposure.
- On the other hand, PTSD could increase the risk of developing a substance use disorder because individuals may abuse substances in an attempt to relieve symptoms of PTSD.

PTSD AND SUBSTANCE USE DISORDERS (continued)

- Substance use could also exacerbate symptoms and/or prolong the course of PTSD by preventing habituation to traumatic memories.
- The HPA axis, extrahypothalamic CRF, and the noradrenergic system are all intimately involved in the stress response, PTSD, and the pathophysiology of substance use disorders.
- Evidence is accumulating to support a role for CRF in mediating the effects of stress in increasing self-administration of drugs.
- Elevated levels of CRF may mediate both the symptoms of hyperarousal and the increased risk for substance use disorders in PTSD.
- Increased CRF may enhance the reinforcing properties of some drugs, worsen the severity of withdrawal symptoms, and exacerbate symptoms of PTSD.

PTSD AND SUBSTANCE USE DISORDERS (continued)

- Neuroimaging studies have shed light on the connection between PTSD, other anxiety disorders, and substance use disorders.
- Amygdala activation occurs during symptom provocation in PTSD, panic disorder, and social phobia.

PTSD AND ADDICTION

Causal Relationships

- Substance use may increase susceptibility to PTSD through increasing anxiety and arousal levels through psychological and/or physiological processes
- PTSD symptoms may lead to substance use as a form of self-medication
- Some studies have found that symptoms of PTSD have preceded the onset of substance use while others have found the opposite order of onset
- Patient's perceptions of the associations between their PTSD symptoms and substance use should be assessed

PTSD AND ADDICTION (continued)

Physiological Effects of Substance Use in PTSD

Substance use may serve to reduce the physiological arousal associated with PTSD. Research has indicated that some substances, e.g., alcohol can reduce physiological reactivity to stressful stimuli or events by enhancing the actions of an inhibitory neurotransmitter (GABA).

Behavioral Effects of Substance Use in PTSD

Individuals may use substances in an attempt to reduce the behavioral avoidance associated with PTSD. The tension reduction caused by some substances may serve as a negative reinforcer

PTSD AND ADDICTION (continued)

Affective Effects of Substance Abuse in PTSD

Substance use may be an attempt to reduce the negative affective symptoms of PTSD, such as numbing of emotional responsiveness

Cognitive Effects of Substance Abuse in PTSD

Substance use may be used to reduce intrusive thoughts and distressing recollections of the traumatic event. Substance use may reduce the distress associated with exposure to events resembling the trauma. The use of substances in response to certain cues may become an automatic behavior

PTSD AND ADDICTION (continued)

Substance-Induced PTSD Symptoms Enhancement

Neurochemical changes involved in drug/alcohol withdrawal may kindle panic attacks. For example, similarities between alcohol withdrawal and PTSD symptoms may cause a misinterpretation of alcohol withdrawal symptoms as signs of anxiety or reminders of the trauma. This could result in further drinking to reduce these symptoms

DIFFERENTIAL DIAGNOSIS: Psychosis versus Posttraumatic Stress

The following may suggest a posttraumatic rather than psychotic process:

- Reexperiencing, as opposed to hallucinations
 - The content of the perceptions is trauma-related (for example, hearing the voice of the perpetrator)
 - The perceptions occur in the context of a triggering experience or trauma-related anxiety
 - The perceptions are not bizarre
- Posttraumatic expectations as opposed to delusions
 - The content of the ideas or fears is related to the traumatic event
 - The patient is able to express an understanding that such ideas or fears are not reasonable

DIFFERENTIAL DIAGNOSIS:
Psychosis versus Posttraumatic Stress (cont)

- Trauma-induced fragmentation as opposed to loosened associations
 - The fragmentation or disorganization occurs only when the patient is talking about upsetting or trauma-related subjects
 - The level of disorganization decreases as the patient becomes less anxious

DIFFERENTIAL DIAGNOSIS:
Psychosis versus Posttraumatic Stress (cont)

The following may suggest a psychotic rather than posttraumatic process:

- Hallucinations as opposed to reexperiencing
 - At least some of the content of the perceptions is not trauma-related
 - The perception is interactive, and/or the patient is observed by others to be talking or laughing to himself or herself
- Delusions as opposed to posttraumatic expectations
 - The content of the ideas/fears is not simply related to the traumatic event, but extends to others areas
- Loosened associations as opposed to trauma-induced fragmentation
 - The cognitive slippage occurs throughout the patient's discourse, whether the patient is anxious or not, and irrespective of the topic of conversation

CUE-INDUCED CRAVING

**ALCOHOLICS ANONYMOUS
HAD IT RIGHT ON TARGET!!!!**



**“STAY AWAY FROM PEOPLE, PLACES AND THINGS”
(associated with drug use)**

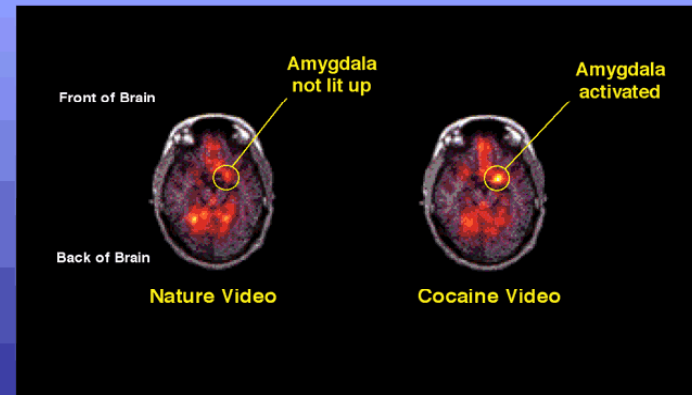
CUE-INDUCED CRAVING (continued)

- Childress, et al. tested whether limbic activation occurs during cue-induced craving in humans. Using PET, regional cerebral blood flow (CBF) was measured in limbic and comparison brain regions.
- PET scans were conducted during exposure to both non-drug-related and cocaine-related videos and during resting baseline conditions.
- The results of the study showed increases in CBF in the amygdala and anterior cingulate occurred in the cocaine users during the cocaine video.
- These results indicate that cocaine craving is associated with differential activation of limbic structures believed to be associated with emotional learning and affect.

CUE-INDUCED CRAVING (continued)

- The amygdala is critical for learning the relationships between biologically significant stimuli and the signals for them. The amygdala shares reciprocal connections with the anterior cingulate. The anterior cingulate has a role in mood and emotional responsivity.
- The authors suggest that the lack of hippocampal activation during craving may indicate a subordination of explicit memory to the amygdala-driven emotional state.
- “The developing brain signature of cue-induced craving is thus consistent with its clinical phenomenology: the drug user is gripped by a visceral emotional state, experiences a highly focused incentive to act, and is remarkably unencumbered by the memory of negative consequences of drug taking.”

The Memory of Drugs



STRESS-INDUCED CRAVING

**ONCE AGAIN,
ALCOHOLICS ANONYMOUS
HAD IT RIGHT ON TARGET!!!!**



**HALT!!!!
“DON’T GET TO HUNGRY, TOO ANGRY,
TOO LONELY, TOO TIRED”**

STRESS-INDUCED CRAVING (continued)

- Relapse rates are high in the treatment of addictive disorders.
- Many studies implicate life stress as an important factor contributing to increased rates of drug and alcohol use and as a trigger for relapse in individuals with substance use disorders.

STRESS-INDUCED CRAVING (continued)

- Recent findings suggest that a history of exposure to drugs of abuse can produce long-lasting changes in the responsivity of central CRF systems, or the systems upon which they act. These changes are manifest in both behavior and in neuronal activity and may be part of a mechanism whereby former drug users remain vulnerable to the effects of stress and relapse after prolonged drug-free periods.
- If certain individuals are more sensitive to stress and/or if they find themselves in an environment where they do not feel that they have adequate control over this stress, then these individuals may be more likely to engage in substance abuse.

INTEGRATED MODEL FOR DEVELOPMENT OF PTSD/BPD/SA

By Linda Gertson, Ph.D.

Disorganized Attachment Relationships

- Primary caregiver(s) cannot regulate infant's states of arousal
 - Deficiency in the hierarchical system of the right hemisphere
 - Inability of higher cortical levels to regulate lower subcortical levels
 - Poor affect regulation
 - Poor communication between right and left hemispheres

INTEGRATED MODEL FOR DEVELOPMENT OF PTSD/BPD/SA (continued)

Ongoing Trauma

- Excess levels of glucocorticoids
 - Sensitization of the HPA Axis
 - High levels of norepinephrine/low levels of cortisol
 - Inability to tolerate stress
 - Damage to hippocampus
 - Poor narrative memory
 - Damage to corpus colosum
 - Impairment in information processing
 - Memories are primarily somatosensory
 - Hyperarousal/numbing

INTEGRATED MODEL FOR DEVELOPMENT OF PTSD/BPD/SA (continued)

Damage to Core Self

- Unstable sense of self
 - Affect instability
 - Poor distress tolerance
 - Shifts between hyperarousal and numbing/dissociation
 - Impulsive behavior
 - Deficits in interpersonal relationships/attachment problems
 - Abandonment issues/feelings of emptiness
 - Alternates between clinging & detachment/idealization/devaluation

INTEGRATED MODEL FOR DEVELOPMENT OF PTSD/BPD/SA (continued)

Use of Drugs/Alcohol

Attempts to modulate states of arousal and regulate affect

Further disruption in neural circuitry and neurobiology

Biological addiction

Impairment in neural structures related to memory

Impairment in social/psychological/intellectual development

Susceptibility to additional trauma (assault/domestic violence)

Use of drugs/alcohol during pregnancy

Impaired parenting behavior

Transgenerational abuse

***People are like stained-glass windows:
They sparkle and shine when the sun is out,
but when the darkness sets in their true beauty is
revealed only if there is a light within.***

Elizabeth Kubler-Ross

COMPLEX PTSD

Complex PTSD appears to be best predicted by insecure, especially disorganized attachment aggravated by childhood abuse. Preexisting insecure attachment status also increases the likelihood that the childhood physical and/or sexual abuse remains unresolved, defined in terms of ongoing disoriented states of mind and lapses in reasoning and discourse with respect to the abuse.

COMPLEX PTSD (continued)

Herman(1992) lists symptom categories of Complex PTSD:

- Poor affect and impulse regulation
- Alterations in consciousness (dissociative episodes)
- Damaged self-perception (feeling different from others; sense of poor self-efficacy)
- Distorted perception of perpetrator
- Disrupted interpersonal relations
- Hopelessness
- Somatization

DEVELOPMENTAL TRAUMA DISORDER

- This diagnosis proposed by Bessel van der Kolk is organized around the issue of triggered dysregulation in response to traumatic reminders, stimulus generalization, and the anticipatory organization of behavior to prevent the recurrence of the trauma impact.
- Van der Kolk supports this new diagnosis in the DSM V because trauma that is prolonged, that first occurs at an early age and that is of an interpersonal nature, can have significant effects on psychological functioning above and beyond PTSD symptomatology.

DEVELOPMENTAL TRAUMA DISORDER (continued)

A. Exposure

1. Multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma (abandonment, betrayal, physical assaults, sexual assaults, threats to bodily integrity, coercive practices, emotional abuse, witnessing violence and death).
2. Subjective Experience (rage, betrayal, fear, resignation, defeat, shame).

DEVELOPMENTAL TRAUMA DISORDER (continued)

B. Triggered pattern of repeated dysregulation in response to trauma cues

- Dysregulation (high or low) in presence of cues. Changes persist and do not return to baseline; not reduced in intensity by conscious awareness.
- Affective
 - Somatic (physiological, motoric, medical)
 - Behavioral (e.g., re-enactment, cutting)
 - Cognitive (thinking that it is happening again, confusion, dissociation, depersonalization)
 - Relational (clinging, oppositional distrustful, compliant)
 - Self-attribution (self-hate and blame).

DEVELOPMENTAL TRAUMA DISORDER (continued)

C. Persistently Altered Attributions and Expectancies

- Negative self-attribution
- Distrust protective caretaker
- Loss of expectancy of protection by others
- Loss of trust in social agencies to protect
- Lack of recourse to social justice/retribution
- Inevitability of future victimization

DEVELOPMENTAL TRAUMA DISORDER **(continued)**

D. Functional Impairment

- Educational
- Familial
- Peer
- Legal
- Vocational

*With all your science can you tell how it is,
and whence it is,
that light comes into the soul?*

Henry David Thoreau

TREATMENT APPROACHES

Treatment approaches for Complex PTSD (Developmental Trauma Disorder) are phase-oriented and include

- Safety and stabilization
- Psychoeducation
- Emotion regulation
- Distress tolerance
- Reframing of symptoms
- Positive self-identity
- Interpersonal problems relating to insecure/disorganized attachment
- Cognitive restructuring
- Self help materials
- Relaxation exercises
- Processing of traumatic memories (when the client has developed sufficient skills for emotional regulation and stress tolerance)

TREATMENT APPROACHES (continued)

Many trauma experts such as van der Kolk, Briere, and Courtois are strongly recommending the inclusion of body therapies such as:

- Yoga
- Meditation
- Sensorimotor psychotherapy (Ogden)
- EMDR (Shapiro)
- Somatic experiencing (Levine)

DIALECTICAL BEHAVIOR THERAPY (DBT) for Borderline Personality Disorder (Linehan)

Borderline Personality Disorder and Emotional Dysregulation

Linehan believes “that borderline individuals are emotionally vulnerable as well as deficient in emotion modulation skills, and that these difficulties have their roots in biological predispositions, which are exacerbated by specific environmental experiences” (p. 43).

Emotional Vulnerability: Includes high sensitivity to emotional stimuli, emotional intensity, and slow return to emotional baseline. The individual reacts quickly. Reactions occur with little provocation. Emotional reactions are extreme. These reactions are long-lasting.

DIALECTICAL BEHAVIOR THERAPY (DBT) (Linehan) (continued)

Emotion Modulation: Individuals with BPD have difficulty learning to tolerate negative emotions and become “negative-emotion-phobic” because they have difficulty distracting themselves from negative, emotionally sensitive stimuli.

Biological Underpinnings: Some researchers suggest that individuals with BPD may have a low threshold for activation of limbic structures associated with emotion regulation.

DIALECTICAL BEHAVIOR THERAPY (DBT) (Linehan) (continued)

BPD and Invalidating Environments

Linehan proposes that invalidating environments facilitate the development of BPD.

Characteristics of Invalidating Environments: In an invalidating environment the communication of private experiences is reacted to with inappropriate, erratic, punishing and/or trivializing responses. These environments are usually intolerant of expressions of negative emotions.

Consequences of Invalidating Environments: The individual does not learn to appropriately label private experiences, to modulate emotional arousal or to tolerate distress.

DIALECTICAL BEHAVIOR THERAPY (DBT) (Linehan) (continued)

Some of the skills taught in DBT are:

- Core mindfulness (observing, describing, participating, taking a nonjudgmental stance, focusing on one thing in the moment, being effective)
- Interpersonal effectiveness (problem-solving and assertiveness skills)
- Emotional regulation (through the use of mindfulness skills, observe and describe current emotional responses in a nonjudgmental manner)
- Distress tolerance (distracting, self-soothing, improving the moment, and thinking of pros and cons)

THERAPY FOR PTSD/ADDICTION

Arguments for immediately addressing the trauma include:

- Relapse and treatment dropout is a risk if trauma symptoms occur and are not addressed
- Suffering may be alleviated sooner if trauma is addressed early
- The trauma symptoms may motivate the substance use

THERAPY FOR PTSD/ADDICTION (continued)

Arguments for a later approach to addressing the trauma:

- Addressing the trauma issues may be threatening or inappropriate for patients who sought treatment primarily for substance abuse
- Substance abusers often have a low tolerance for negative affects, especially in early abstinence (discussing trauma requires the ability to deal with powerful and conflicting affects and cognitions related to re-experiencing the trauma)
- Therapeutic interventions directed to underlying conflicts may not be successful in patients continuing to abuse substances
- Severity of PTSD symptoms may subside with abstinence

THERAPY FOR PTSD/ADDICTION (continued)

There are currently many manuals for treating patients with substance dependence and PTSD

All these manuals have similar contents such as:

- Emphasis on safety
- Education about the nature and consequences of abuse
- Description of the symptoms of PTSD
- Setting boundaries
- Self care/self-soothing
- Empowerment
- Education about substance abuse
- Information about how trauma and substance use interact

THERAPY FOR PTSD/ADDICTION (continued)

Manual contents (continued)

- Self-destructive behaviors
- Emotion regulation
- Stress tolerance
- Relapse prevention
- Healthy relationships/Intimacy and trust

Seeking Safety: A Treatment Manual for PTSD and Substance Abuse by Lisa M. Najavits is an evidenced-based manual recommended by SAMHSA.

The Trauma Recovery and Empowerment Model (TREM) combines interpersonal, relational, client-centered cognitive-behavioral, and psychodynamic models.

**VENTURA COUNTY BEHAVIORAL
HEALTH
INTEGRATED DUAL DIAGNOSIS
TREATMENT PROGRAM**

TARGET POPULATION

- Over 40 percent of the VCBH client population has co-occurring mental illness and substance use disorders.
- The interaction of mental illness and substance use disorders in this population was found to be associated with:
 - symptom severity
 - hospitalizations
 - incarcerations
 - family conflict
 - homelessness and other residential problems
 - health problems
 - medication non-compliance
 - unemployment
 - socio-economic status.

CLIENTS WITH TRAUMA HISTORY

| | <u>Males</u> | <u>Females</u> |
|---------------------------------|--------------|----------------|
| <u>Childhood Physical Abuse</u> | 48% | 52% |
| <u>Childhood Sexual Abuse</u> | 32% | 63% |
| <u>Adult Abuse</u> | 13% | 78% |
| <u>Abuse of Any Type</u> | 48% | 94% |

Total N = 213

IDDT SERVICES

- The IDDT Program provides integrated treatment for individuals with mental illness and co-occurring substance abuse.
- The Program rests on six clinical evidenced-based program elements:
 - accurate and thorough assessment
 - client-centered recovery plans
 - dual diagnosis counseling (individual therapy with licensed clinicians)
 - integrated dual diagnosis groups
 - appropriate psychopharmacology
 - case management.

PROGRAM OUTCOMES

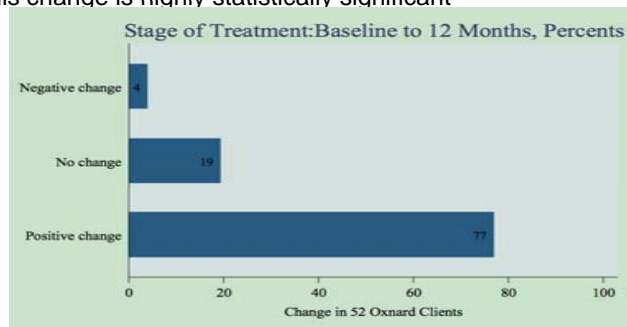
PROGRAM OUTCOMES

Stages of Treatment

- Clients who recover from dual disorders participate in the treatment process through a series of four stages:
 - engagement*
 - persuasion*
 - active treatment*
 - relapse prevention*
- The goal of treatment is to assist clients with movement along this continuum of stages.

Graph of Stage of Treatment Change over 12 Months

This change is highly statistically significant



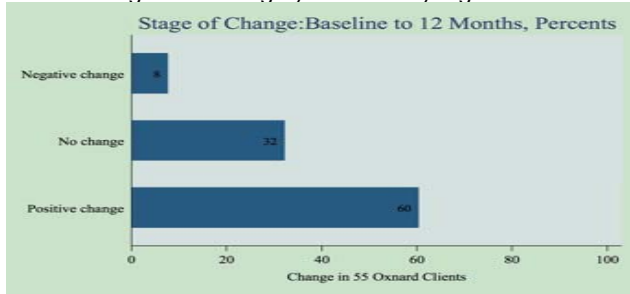
PROGRAM OUTCOMES (continued)

Stages of Change

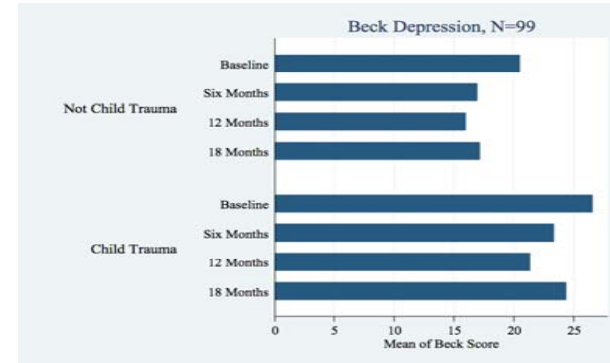
- People who change maladaptive behaviors progress through a series of distinct stages:
 - precontemplation*
 - contemplation*
 - preparation*
 - action*
 - maintenance*
- As with stages of treatment, the goal is to assist clients in movement along the continuum of the stages of change.

Graph of Stage of Change Transitions over 12 Months

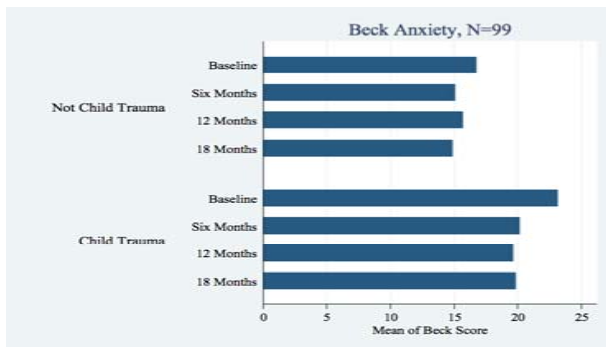
This change is also highly statistically significant



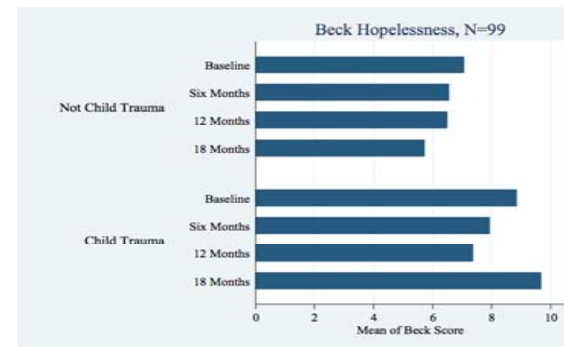
Mean Beck Depression Scale Scores



Mean Beck Anxiety Scale Scores



Mean Beck Hopelessness Scale Scores



PROGRAM OUTCOMES (continued)

Risk Reduction Factors (First 6 Months of Treatment)

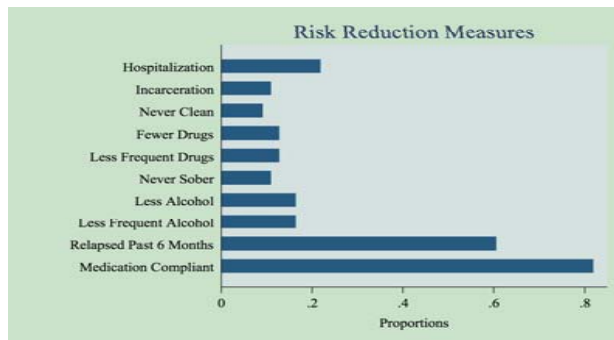
- 80 % of the clients in the IDDT Program avoided hospitalizations
- and incarcerations
- 80% reduced the frequency and/or amount of substances (if not totally clean and sober)
- 81% of the clients were compliant with their medication regimen
- Only 1% of the clients were never completely clean and sober (for a period of 30 continuous days) during the first 6 months of treatment

Statistical significance of association between number of group therapy or individual therapy sessions and outcomes at six months (N=99)

| Outcome | Group Sessions | Individual Visits | Attend12-step |
|------------------------------|-----------------|-----------------------------|-----------------|
| Hospitalized in the 6 months | Not Significant | Significant Positive Effect | Not Significant |
| SATS improvement | Not Significant | Significant Positive Effect | Not Significant |
| Combined outcomes* | Not Significant | Significant Positive Effect | Not Significant |

*Combined outcomes includes hospitalization, jail, never being clean, never being sober, relapsing. Each outcome was assigned a numeric value of 1, resulting in groups of 0, 1, 2, 3 and 4 outcomes having occurred (though in practice no one had 4).

Graph of Indicators of Reduced Risk Associated with Treatment at 12 Months

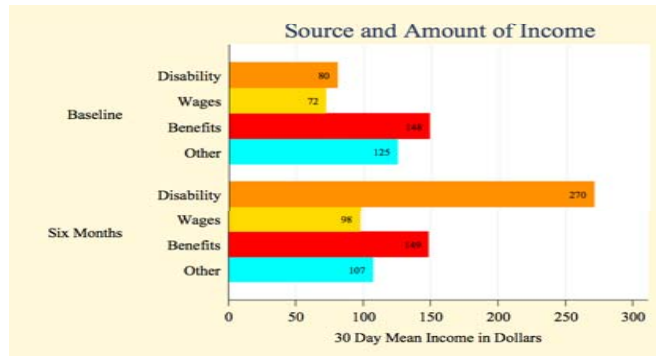


PROGRAM OUTCOMES (continued)

Changes in Income Categories for 53 Clients Homeless at Program Entry

| | <u>Baseline</u> | <u>Six Months</u> |
|-------------------------------------|-----------------|-------------------|
| <i>Disability Income</i> | 5 persons | 16 persons |
| <i>Average Disability Income</i> | \$80.00 | \$270.00 |
| <i>Employment</i> | 0 persons | 9 persons |
| <i>Mean Wage Increase Per Month</i> | \$3,803.00 | \$5,072.00 |

Graph of Changes in Major Income Categories for Clients Homeless at Time of Entry and at Six Months

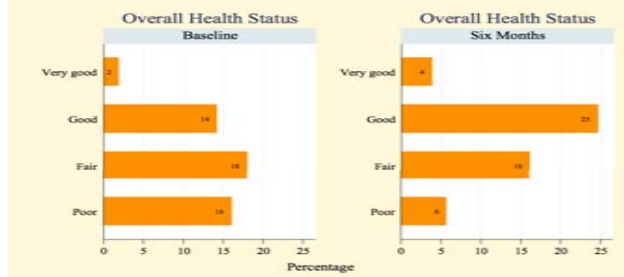


PROGRAM OUTCOMES (continued)

The next graph shows how client self-rating of overall health status improved. In particular the percentage with poor health declined dramatically.

Graph of Overall Self-Rating of Health

Changes in "Good" and "Poor" are statistically significant



PROGRAM OUTCOMES (continued)

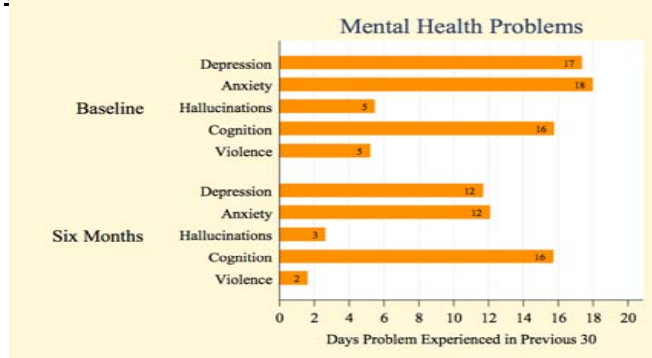
Mean Number of Days the Symptom was Experienced During the Previous 30 Days

(All changes are statistically significant)

| | Baseline | Six Months |
|------------------|----------|------------|
| Depression | 17.3 | 11.7 |
| Anxiety | 18.0 | 12.0 |
| Hallucinations | 5.6 | 2.6 |
| Cognition* | 16 | 16 |
| Violent Behavior | 5.2 | 1.6 |

*(comprehension/concentration/memory – these mental functions can be impaired for an extended amount of time following abstinence)

**Graph of Mean Number of
Symptoms (experienced per day)
at Baseline and Six Months**



CLIENT TESTIMONIALS

- “Participating in group discussion in IDDT with other people facing the same problems – homelessness, isolation, poverty, unemployment, depression and addiction – has helped me feel less uniquely impaired.”
- “The IDDT Program has allowed me to learn a way of dealing with life on life’s terms.”
- “I know more about myself than I ever have.”
- “This program has helped me to be more aware of my problems and how to better manage them. It has also helped me to realize that I have the capacity to be a regular person.”
- “From my perspective, there is only one perspective. You have to treat both disorders at the same time.”

***Here is the test to find whether your mission
on earth is finished.
If you’re alive, it isn’t***

Richard Bach