**Trauma & Recovery**



*Just like there's always time for pain, there's always time for healing.*

*~ Jennifer Brown*

**Overview & Objectives**

Treatment facilities licensed in Texas are required to be “trauma informed”. One of guiding principles of recovery identified by SAMHSA states, “Recovery is supported by addressing trauma”. Those seeking long-term recovery support services often speak of childhood traumas. Research shows when this trauma is not addressed the likelihood of return to use is much greater. An understanding of this is important to those in and people supportive of recovery.

The contents in this module will also provide an overview for several well-known authors on trauma and their concept of the Stages of Recovery.

Material in this module will assist in an overview the Adverse Childhood Experiences (ACE) assessment.

**Objectives**

Upon the completion of this material, students should proficiently:

* Report back tools and techniques used to treat people with trauma.
* List the 4 R’s of a Trauma-Informed approach.
* Recall 3 ACE areas.

**Addiction and Recovery Professionals**

At a minimum a trauma-informed professional should

* Become trauma aware and knowledgeable about the impact and consequences of traumatic experiences for individuals, families, and communities.
* Evaluate and initiate use of appropriate trauma-related screening and assessment tools.
* Learn the core principles and practices that reflect TIC
* Decrease the inadvertent re-traumatization that can occur from implementing standard organizational policies, procedures, and interventions with individuals, including clients and staff, who have experienced trauma or are exposed to secondary trauma.

Trauma-informed services bring to the forefront the belief that trauma can pervasively affect an individual’s wellbeing, including physical and mental health.

**Trauma in Brain Architecture**

Memories are tagged as being important as we grow.



If it fires together, it wires together.

**Advice**

Advice to Counselors:

The history of trauma raises various clinical issues. Many counselors do not have extensive training in treating trauma or offering trauma-informed services and may be uncertain of how to respond to clients’ trauma-related reactions or symptoms. Some counselors have experienced traumas themselves that may be triggered by clients’ reports of trauma. Others are interested in helping clients with trauma but may unwittingly cause harm by moving too deeply or quickly into trauma material or by discounting or disregarding a client’s report of trauma. Counselors must be aware of trauma related symptoms and disorders and how they affect clients in behavioral health treatment.

Counselors with primary treatment responsibilities should also have an understanding on how to recognize trauma-related reactions, how to incorporate treatment interventions for trauma-related symptoms into clients’ treatment plans, how to help clients build a safety net to prevent further trauma, how to conduct psychoeducational interventions, and when to make treatment referrals for further evaluations or trauma-specific treatment services.

All treatment staff should recognize that traumatic stress symptoms or trauma-related disorders should not preclude an individual from mental health or substance use treatment and that all co-occurring disorders need to be addressed on some level in the treatment plan and setting. For example, helping a client in substance abuse treatment gain control over trauma-related symptoms can greatly improve the client’s chances of substance abuse recovery and lower the possibility of relapse (Farley, Golding, Young, Mulligan, & Minkoff, 2004; Ouimette, Ahrens, Moos, & Finney, 1998).

Many people who have substance use disorders have experienced trauma as children or adults (Koenen, Stellman, Sommer, & Stellman, 2008; Ompad et al., 2005).

Substance abuse is known to predispose people to higher rates of traumas, such as dangerous situations and accidents, while under the influence (Stewart & Conrod, 2003; Zinzow, Resnick, Amstadter, McCauley, Ruggiero, & Kilpatrick, 2010).

As a result of the lifestyle associated with substance abuse (Reynolds et al., 2005). In addition, people who abuse substances and have experienced trauma have worse treatment outcomes than those without histories of trauma (Driessen et al., 2008; Najavits et al., 2007).

Knowing the high predisposition of trauma and the lower treatment outcomes, it is imperative that addiction professionals be educated in this area.

*\*Note the old language used in these statements is due to the date published.*

**From First Contact**

From the moment a potential client contacts an agency it is important that every person in the staff – clinicians and support staff – understand that a trauma history can impact the response of a client. A trauma history can greatly impact the client receptiveness to interventions, policies, rules, and daily procedures in an agency.

Foremost, a behavioral health service provider must recognize the prevalence of trauma and its possible role in an individual’s emotional, behavioral, cognitive, spiritual, and/or physical development, presentation, and well-being. Being vigilant about the prevalence and potential consequences of traumatic events among clients allows counselors to tailor their presentation styles, theoretical approaches, and intervention strategies from the outset to plan for and be responsive to clients’ specific needs. Although not every client has a history of trauma, those who have substance use and mental disorders are more likely to have experienced trauma. Being trauma aware does not mean that you must assume everyone has a history of trauma, but rather that you anticipate the possibility from your initial contact and interactions, intake processes, and screening and assessment procedures (Najavits, et al., 2014).

It is important for professionals to realize the trauma response is the best coping skill the client has. This understanding can help professionals shift their belief that the behavior is an issue of resilience rather than strictly pathology.

**Pathology:** Diagnosing, implying something is wrong with client.

**Resilience:** Viewing the client difficulties as a response to trauma.

A change in this perspective can allow the professional to begin the relationship with hope, focused on the strengths of the client. This will assist in building a more collaborative relationship.

A trauma-informed perspective views trauma related symptoms and behaviors as an individual’s best and most resilient attempt to manage, cope with, and rise above his or her experience of trauma. Some individuals’ means of adapting and coping have produced little difficulty; the coping and adaptive strategies of others have worked in the past but are not working as well now. Some people have difficulties in one area of life but have effectively negotiated and functioned in other areas (Najavits, et al., 2014).

**Actively Work to Minimize Re-Traumatizing**

Trauma-informed treatment providers acknowledge that clients who have histories of trauma may be more likely to experience particular treatment procedures and practices as negative, reminiscent of specific characteristics of past trauma or abuse, or retraumatizing— feeling as if the past trauma is reoccurring or as if the treatment experience is as dangerous and unsafe as past traumas. For instance, clients may express feelings of powerlessness or being trapped if they are not actively involved in treatment decisions; if treatment processes or providers mirror specific behavior from the clients’ past experiences with trauma, they may voice distress or respond in the same way as they did to the original trauma. Among the potentially retraumatizing elements of treatment are seclusion or “time-out” practices that isolate individuals, mislabeling client symptoms as personality or other mental disorders rather than as traumatic stress reactions, interactions that command authority, treatment assignments that could humiliate clients (such as asking a client to wear a sign in group that reflects one of their treatment issues, even if the assignment centers on positive attributes of the client), confronting clients as resistant, or presenting treatment as conditional upon conformity to the provider’s beliefs and definitions of issues (Najavits, et al., 2014).

**Broad Lens**

Trauma must be viewed through a broad lens. Different people respond differently to traumatic situations.

Many factors influence the response to traumatic situations, including:

Individual attributes, developmental factors, life history, type of trauma, specific characteristics of the trauma, amount and length of trauma exposure, cultural meaning of traumatic events, number of losses associated with the trauma, available resources, and community reactions (Najavits, et al., 2014).

**What is Trauma?**

Trauma is the result of a distressing event or series of events. It is an overwhelming amount of stress that exceeds one’s ability to cope or integrate the experiences. Trauma is a developmental obstacle in normal emotional development. Trauma can manifest in physical, psychological, and addictive symptoms and diagnoses. (Engle, 2017).

Gabor Mate explains the connection between addiction and trauma in this video, [“What is Addiction?”](https://www.youtube.com/watch?v=T5sOh4gKPIg&feature=youtu.be)

**Melissa Engle**

A 25-year veteran in the treatment of trauma, using the Integrated Model developed by she and Dr. Colin Ross, Melissa Engle explains all of the following can result in trauma:

|  |  |
| --- | --- |
| Physical Abuse Sexual Abuse Violence/Assault Emotional Abuse DeathVerbal Abuse Accident Spiritual Abuse Bullying RapeViolent Workplace Childhood Neglect of Physical Needs Loss of Job Medical Diagnosis/Chronic Illness/Loss of FunctioningInfertility/Miscarriage Natural Disasters Witnessing Something Traumatic Psychiatric IssuesConsequences related to addiction  | AbandonmentChildhood Neglect of Emotional Needs Burglary Parents Who Had Poor/Dysfunctional Coping Skills Chaotic/Dysfunctional Car WreckAbortion Domestic Violence Divorce/Break Up Suicide of Loved OneWar/Combat/Political ViolenceEnvironment Financial Difficulties Birth DefectsHigh Stress Job Pregnancy/Child Birth Hospitalization Learning DisabilityMultiple life stressors Chronic recurrence of use and/or return to treatment (Engle, 2017). |

This list gives a much greater scope of trauma than previously imagined. What is traumatic to one person may not be traumatic to another. A person who learned healthy coping skills in childhood will likely be better equipped to deal with events in adulthood. This might explain the reason one person can go through a traumatic event with fewer wounds than another.

Engle explains what causes stress as:

* Unresolved emotional pain (past and present)
* Uncertainty
* Lack of information
* Loss of control

Because stress releases cortisol people who remain in the flight or fight state can be impacted physically. Physical damage can occur to the body, heart, central nervous system, intestines and immune system. This can also shut down the prefrontal cortex which manages impulse control and decision-making capabilities.

The ability to manage stressful situations and the uncomfortable associated emotions is a learned experience, taught by primary care takers. People either learn what is healthy or what is unhealthy in regard to emotional attunement (Engle, 2017).

**Ask yourself:**

Where did your parents learn how to manage their emotions? From their parents.

Unhealthy emotional responding and the often resulting mental and physical symptoms, as well as many addictive patterns can often be seen across multiple generations.

Every person is potentially at risk for addiction, given this concept. How each person copes can change the course for them.

Unhealthy ways people cope listed by Engle as:

|  |  |
| --- | --- |
| Substances Self-MutilationMedication/PillsSexIntellectualizingShameDrama King/QueenEntitlementDenialEating/Not EatingDissociationAlter EgosExtreme CollectingGamblingGamingPornographyWorkaholismPerfectionismShoppingHumorFantasyReligionExerciseHomicidal IdeationNarcissism/ArroganceDepersonalization | ConfusionShopliftingMasturbationPromiscuityFlashbacksMemoriesLiving in the pastDrama TriangleSuicidal IdeationSomatizationAnxietyOCD Thinking & BehavingHobbiesNumbnessRageSadness/DepressionIsolationBlack & White ThinkingIdealization/DevaluationMagical Childlike ThinkingTerminally UniqueSleepingDiscountingSmokingBeing Controlling (Engle, 2018). |

**Emotions and Diagnoses**

In her “Spectrum of Emotions” published in 2004, Engle highlights the connection between emotions, mental health diagnoses, and physical diagnoses.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medical Diagnoses** | **Unhealthy under-responding** | **Healthy** | **Unhealthy over-responding** | **Psychiatric Diagnoses** |
| Headaches and MigrainesHigh Blood PressureFibromyalgiaChronic FatigueChronic PainFertility IssuesIrritable Bowel | Numbing | Anger | Rage | DepressionDisordered EatingAnxietySubstance UsePTSDDissociative Disorder Process addiction |
| Sad | Depression |
| Vulnerable | Despair/Hopeless |
| Happy | Helpless |
| Guilt | Mania |
| Fear | Shame |
| Lonely | Terror/Panic |

**Trauma**

Experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual’s physical, social, emotional, or spiritual well-being. (Najavits, et al., 2014)

Individuals who have experienced trauma are at an elevated risk for substance use disorders.

**Secondary Trauma**

Trauma-related stress reactions and symptoms resulting from exposure to another individual’s traumatic experiences, rather than from exposure directly to a traumatic event. Secondary trauma can occur among behavioral health service providers across all behavioral health settings and among all professionals who provide services to those who have experienced trauma. (Najavits, et al., 2014)

It is important to focus on this when preparing to become an addiction professional, as a high number of the population you will service are likely to have trauma, thus, the professionals are at risk for experiencing secondary trauma.

Organizations and individual professionals must develop strategies to address secondary trauma and foster self-care.

Trauma is similar to a rock hitting the water’s

surface.

The impact first creates the largest

wave,

which is followed by ever-expanding,

but less intense, ripples.

Likewise, the influence of

a given trauma can be broad, but generally, its

effects are less intense for individuals further

removed from the trauma;

eventually, its impact dissipates all around. For trauma survivors,

the impact of trauma can be far-reaching and

can affect life areas and relationships long after

the trauma occurred.

This analogy can also

broadly describe the recovery process for individuals who have experienced trauma and

for those who have the privilege of hearing their

stories. As survivors reveal their trauma-related

experiences and struggles to a counselor or another caregiver,

the trauma becomes a shared experience,

although it is not likely to be as intense for the caregiver as it was for the individual who experienced the trauma.

The caregiver may hold onto the trauma’s known

and unknown effects or may consciously decide

to engage in behaviors that provide support to

further dissipate the impact of this trauma and

 the risk of secondary trauma (Najavits, et al., 2014)

 **Trauma-Informed Approach**

This approach includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic (Najavits, et al., 2014).

The Trauma-Informed approach involves four key elements:

1. realizing the prevalence of trauma;
2. recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce;
3. responding by putting this knowledge into practice; and
4. resist re-traumatization.

These key elements are also referred to as the 4-R’s by SAMHSA

|  |
| --- |
| ***Realizes*** the widespread impact of trauma and understands potential paths for recovery |
| ***Recognizes***the signs and symptoms of trauma in clients, families, staff, and others involved with the system |
| ***Responds***by fully integrating knowledge about trauma into policies, procedures, and practices |
| Seeks to actively resist ***re-traumatization*** |

**Key Principles of a Trauma-Informed Approach**

SAMHSA defined [Six Key Principles of a Trauma-Informed Approach](https://www.samhsa.gov/nctic/trauma-interventions)

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting or sector-specific:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

**Trauma-Informed Care**

TIC is a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. (Najavits, et al., 2014)

**The 3 E’s of Trauma Informed Care**

|  |  |
| --- | --- |
| **Events** | Events and circumstances may include the actualor extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development.  |
| **Experience** | The individual’s **experience** of these events or circumstances helps to determine whether itis a traumatic event.  |
| **Effects** | The long-lasting adverse **effects** of the event are a critical component of trauma.  |

In SAMHSA’s [Concept of Trauma and Guidance for a Trauma-Informed Approach](https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf), it is pointed out “a trauma-informed approach seeks to **resist re-traumatization** of clients as well as staff. Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission.”

**Trauma-Specific Interventions**

SAMHSA lists: [Trauma-Specific Interventions,](https://www.samhsa.gov/nctic/trauma-interventions) indicating programs with Trauma-specific interventions recognize the following:

* The survivor's need to be respected, informed, connected, and hopeful regarding their own recovery
* The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety
* The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers

**Trauma-Specific Treatment Services**

These services are evidence-based and promising practices that facilitate recovery from trauma. The term “trauma-specific services” refers to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders. (Najavits, et al., 2014).

Providers should:

Use strength-based counseling methods;

Familiarize clients with trauma related resources. Some are listed in this module; and

Foster resilience building and coping skills.

**Advice to Counselors and Administrators Using Strengths-Oriented Questions from SAMHSA’s TIP 57:**

Knowing a client’s strengths can help you understand, redefine, and reframe the client’s presenting problems and challenges. By focusing and building on an individual’s strengths, counselors and other behavioral health professionals can shift the focus from “What is wrong with you?” to “What has worked for you?” It moves attention away from trauma-related problems and toward a perspective that honors and uses adaptive behaviors and strengths to move clients along in recovery.

Potential strengths-oriented questions include:

The history that you provided suggests that you’ve accomplished a great deal since the trauma. What are some of the accomplishments that give you the most pride?

What would you say are your strengths?

How do you manage your stress today?

What behaviors have helped you survive your traumatic experiences (during and afterward)?

What are some of the creative ways that you deal with painful feelings?

You have survived trauma. What characteristics have helped you manage these experiences and the challenges that they have created in your life?

If we were to ask someone in your life, who knew your history and experience with trauma, to name two positive characteristics that help you survive, what would they be?

What coping tools have you learned from your \_\_\_\_\_ (fill in: cultural history, spiritual practices athletic pursuits, etc.)?

Imagine for a moment that a group of people are standing behind you showing you support in some way. Who would be standing there? It doesn’t matter how briefly or when they showed up in your life, or whether or not they are currently in your life or alive.

How do you gain support today? (Possible answers include family, friends, activities, coaches, counselors, other supports, etc.)

What does recovery look like for you?

 **Approaches**

SAMHSA also provides more specific information on many well-known trauma informed approaches, including:

* Addiction and Trauma Recovery Integration Module (ATRIUM)
* Essence of Being Real
* Risking Connection®
* Sanctuary Model®
* Trauma, Addiction, Mental Health, and Recovery (TAMAR)
* Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
* Trauma Recovery and Empowerment Model (TREM and M-TREM)

**Treatments for Post-Traumatic Stress Disorder (PTDS)**

* Individual Psychotherapy;
* Cognitive Behavioral Therapy;
* Eye Movement Desensitization and Reprocessing (EMDR);
* Group Therapy; and
* Medication.

More detailed information can be found on a [pdf](http://www.traumacenter.org/resources/pdf_files/PTSD_Treatments.pdf) created by The Trauma Center with funding from the Massachusetts Office for Victim’s Assistance ([MOVA](https://www.mass.gov/orgs/massachusetts-office-for-victim-assistance)).

**Talking About Trauma**

One piece of information many in the addiction profession already know and all *need to know* is: talking about trauma ***does not*** put the trauma and pain in the past. Therefore, therapeutic approaches such as Exposure Therapy, may not benefit – and may actually cause harm to – someone with trauma.

**Child Abuse**

Some trauma is a result of childhood abuse. Taken directly from the CDC website, here are some important terms:

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| --- | --- |
| **Child abuse and neglect** | Any act or series of acts of commission or omission by a parent or other caregiver (e.g., clergy, coach, or teacher) that results in harm, potential for harm, or threat of harm to a child. |
| **Acts of Commission** **(Child Abuse)** | * Words or overt actions that cause harm, potential harm, or threat of harm.
* Deliberate and intentional. However, harm to a child might not be the intended consequence. Intention only applies to caregiver acts—not the consequences of those acts.

The following types of abuse involve acts of commission:* Physical abuse
* Sexual abuse
* Psychological abuse
 |
| **Acts of Omission (Child Neglect)** | * Failure to provide needs or to protect from harm or potential harm.
* The failure to provide for a child’s basic physical, emotional, or educational needs or to protect a child from harm or potential harm. Like acts of commission, harm to a child might not be the intended consequence.

The following types of neglect involve acts of omission:* Physical neglect
* Emotional neglect
* Medical and dental neglect
* Educational neglect
* Inadequate supervision
* Exposure to violent environments
 |

Available from: [Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements](https://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf)

**Bessel van der Kolk**

Yale University Annual NEA-BPD (National Education Alliance for Personality Disorder) [conference information and registration.](https://medicine.yale.edu/psychiatry/bpdconference/home.aspx)

In this video, you can view a 2013 Yale University Lecture by Bessel van der Kolk, M.D., an expert in the field of trauma. [Childhood Trauma, Affect Regulation, and Borderline Personality Disorder.](https://www.youtube.com/watch?v=N2NTADxDuhA&feature=youtu.be)

**Adverse Childhood Experiences (ACE)**

Used in many treatment centers, the Adverse Childhood Experiences (ACE) questionnaire provides valuable information to begin working with someone.

ACEs can indicate risk factors.

[Adverse Childhood Experiences](https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences) are defined by SAMHSA as,

 Stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person’s lifespan, including those associated with substance misuse.

SAMHSA indicates ACEs could include:

* Physical abuse
* Sexual abuse
* Emotional abuse
* Physical neglect
* Emotional neglect
* Intimate partner violence
* Mother treated violently
* Substance misuse within household
* Household mental illness
* Parental separation or divorce
* Incarcerated household member

Conducted from 1995 – 1997, the Centers for Disease Control (CDC) and Kaiser Permanente ACE Study was one of the largest investigations of childhood abuse and neglect and later-life health and well-being ("Violence Prevention", 2016).

**The Adverse Childhood Experiences Pyramid** [graphic](https://www.samhsa.gov/capt/sites/default/files/images/adverse-childhood-experiences-pyramid-lg.jpg).

*See Handout 1 Adverse Childhood Experience Assessment*



The study is written about in [Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults](https://www.ajpmonline.org/article/S0749-3797%2898%2900017-8/abstract) journal article in the AJPM (American Journal of Preventive Medicine).

[Presentation graphics](https://www.cdc.gov/violenceprevention/acestudy/ace_graphics.html) of study.

Read [The Adverse Childhood Experiences Study — the largest, most important public health study you never heard of — began in an obesity clinic.](https://acestoohigh.com/2012/10/03/the-adverse-childhood-experiences-study-the-largest-most-important-public-health-study-you-never-heard-of-began-in-an-obesity-clinic/))

**CDC**

The CDC’s Adverse Childhood Experiences Study ([ACE Study](http://www.cdc.gov/ace/index.htm)) [uncovered](http://www.cdc.gov/ace/findings.htm) a stunning link between childhood trauma and the chronic diseases people develop as adults, as well as social and emotional problems.

This [includes](http://www.newyorker.com/reporting/2011/03/21/110321fa_fact_tough) heart disease, lung cancer, diabetes and many autoimmune diseases, as well as depression, violence, being a victim of violence, and suicide.

The first research results[were published in 1998, followed by more than 70 other publications through 2015](https://acestoohigh.com/research/).

They showed that:

* childhood trauma was very common, even in employed white middle-class, college-educated people with great health insurance;
* there was a direct link between childhood trauma and adult onset of chronic disease, as well as depression, suicide, being violent and a victim of violence;
* more types of trauma increased the risk of health, social and emotional problems.
* people usually experience more than one type of trauma – rarely is it only sex abuse or only verbal abuse.

Two thirds of the 17,000 people in the ACE Study had an ACE score of at least one —[87 percent of those](http://www.acestudy.org/yahoo_site_admin/assets/docs/ARV1N1.127150541.pdf) had more than one.

Thirty-six states and the District of Columbia have done their own ACE surveys; their results are similar to the CDC’s ACE Study.

**Phased Framework**

Dr. Pierre Janet conceived of a phased framework of trauma recovery in the late 1800’s. Dr. Judith Herman brought new life to these phases in her work, *Trauma and Recovery* in 1992.



**Stages of Recovery: Judith Herman**

Taken from Judith Herman’s book, [Trauma and Recovery](https://www.amazon.com/Trauma-Recovery-Aftermath-Violence-Political/dp/0465061710/ref%3Dsr_1_1_sspa?ie=UTF8&qid=1528842820&sr=8-1-spons&keywords=trauma+and+recovery+judith+herman&psc=1) the following is a description of her three-stage model of recovery from trauma:

|  |  |
| --- | --- |
| **Stage 1** | Dealing with and overcoming such problems, and of any helpful therapy or counseling, is about:* Getting a ‘road map’ of the healing process.
* Setting treatment goals and learning about helpful approaches to reaching those goals.
* Establishing safety and stability in one’s body, one’s relationships, and the rest of one’s life.
* Tapping into and developing one’s own inner strengths, and any other potentially available resources for healing.
* Learning how to regulate one’s emotions and manage symptoms that cause suffering or make one feel unsafe.
* Developing and strengthening skills for managing painful and unwanted experiences, and minimizing unhelpful responses to them.
 |
| **Stage 2** | Often referred to as ‘remembrance and mourning.’ * Reviewing and/or discussing memories to lessen their emotional intensity, to revise their meanings for one’s life and identity, etc.
* Working through grief about unwanted or abusive experiences and their negative effects on one’s life.
* Mourning or working through grief about good experiences that one did not have, but that all children deserve.
 |
| **Stage 3** | Reconnecting with people.  |

**Stages of Recovery: Mic Hunter**

Mic Hunter, author of [Abused Boys: The Neglected Victims of Sexual Assault](https://www.amazon.com/Abused-Boys-Neglected-Victims-Sexual/dp/0449906299/ref%3Dsr_1_1?ie=UTF8&qid=1528843245&sr=8-1&keywords=abused+boys+mic+hunter), describes the Stages of Recovery as:

|  |  |
| --- | --- |
| **1** | **Denial** – “Nothing happened” |
| **2** | **Bargaining** – “Something happened, but…” |
| **3** | **Anger** – “Something happened, and I’m angry about it!” |
| **4** | **Sadness** – “Something happened, and it cost me a lot.” |
| **5** | **Acceptance** – “Something happened, and I have healed from it.” |

**Trauma from the Brain Perspective**

Jim Hopper explains trauma as it pertains to brain circuitry. Hopper defines **Seeking Circuitry** as the brain’s focus on “Things that are bad for us, good for us, or somewhere in between.”

A bulk of Mr. Hopper’s information is free and can be found on his website. He recommends beginning with [Key Brain Circuitries](http://www.jimhopper.com/brain-healing-and-happiness/key-brain-circuitries/). In the web-education, he breaks down circuitry of:

* Fear circuitry
* Seeking circuitry
* Satisfaction circuitry
* Embodiment circuitry
* Default Mode circuitry
* Executive circuitry

|  |  |
| --- | --- |
| **Fear circuitry**  | * Includes the amygdala and other brain regions (hypothalamus and periaqueductal gray).
* The fear circuitry triggers and implements extreme fear responses.
* Isn’t only for what scares or terrifies us. It’s triggered by *anything* we find unpleasant and want to avoid.
* Most studied circuitries in neuroscience and a major focus of research in trauma.
 |
| **Seeking circuitry** | * One of the most important circuitries in the brain.
* Most neuroscientists still just use the term ‘reward circuitry.
* Enables us to want and seek [*anything* that involves effortful activity](http://www.jimhopper.com/pdf/SalamoneCorrea2012.pdf).
* Drives our attempts to avoid and escape from unwanted experiences that have activated the circuitry of fear and aversion.
 |
| **Satisfaction circuitry** | * May also be referred to as “reward” circuitry.
* Opioids in the brain (and their receptors on brain cells) are centrally involved in feelings of satisfaction and contentment.
* Any time we feel contented, this circuitry is involved.
 |
| **Embodiment circuitry** | * Brings together all information coming from the body (e.g., sensations of movement, touch, tension, pressure, warmth).
* Includes pleasant and wanted sensations, including those associated with substance intoxication and behaviors that people find addicting.
 |
| **Default Mode circuitry** | * The part of the brain that tends to wander.
* It is what our brains do whenever we are resting or not fully absorbed in anything else.
 |
| **Executive circuitry** | * Consists of the prefrontal cortex.
* Allows us to think, plan, solve problems, imagine the future, manage our emotions and impulses, remember our highest values and goals, and make thoughtful decisions.
 |

A complimentary activity to this table is this 1-page exercise, What I Do with My Seeking Circuitry for reflecting on what you’ve been doing with your seeking circuitry.

**Dr. Colin Ross**

In North Texas Dr. Colin Ross has authored and conducted research regarding trauma. Dr. Colin Ross is an internationally renowned clinician, researcher, author and lecturer in the field of dissociation and trauma-related disorders. He is the founder and President of The Colin A. Ross Institute for Psychological Trauma.

[The Ross Institute](http://www.rossinst.com/)

**Trauma Sensitive Yoga**

TSY is an evidenced-based treatment that provides many important tools for people with trauma.

**Dr. Justin Watts and Deidre O’Sullivan**

Watch this presentation:

Presented by Justin Watts, Ph.D., NCC and Deirdre O'Sullivan, Ph.D., CRC during the UNT Recovery Conference in 2017, Addressing Treatment Needs for [Individuals with Substance Use Disorders and a History of Child-Maltreatment](https://www.youtube.com/watch?v=4EdIB7VZlvk&feature=youtu).

**Presentation Description**: The experience of child-maltreatment is often the precursor to many negative health related outcomes including: substance use disorders, mental health related issues, trauma and disability. Individuals who experience early trauma are often subjected to impoverished relational environments that contribute to negative coping skills and developmental deficits which are significantly related to later substance using behaviors, and often interfere with treatment when intervention is sought.

This presentation outlines rates of trauma history including child-maltreatment histories among individuals who are seeking substance use treatment, and summarizes results from several studies examining the relationship between child maltreatment and negative health outcomes which are intended to guide the development of individualized treatment plans addressing the complex nature of presenting issues for this population.

**Project Reach**

The Trauma Center at Justice Resource Institute developed a useful resource for mental health professionals who work with clients who have experienced trafficking-related trauma, [Utilizing Trauma-Informed Approaches to Trafficking-related Work.](http://www.traumacenter.org/resources/H-O%20Trauma-Informed%20Case%20Study_final_2.pdf)

This resource covers the core areas impacted, such as:

* Regulation of Affect and Impulses;
* Attention;
* Self-Perception;
* Relations with others; and
* Somatization.

This resource was designed for mental health professionals, but appears to be useful for everyone working in the addiction profession, as it contains brief case examples, what you might see in a person experiencing impact from trauma, and tips.

**The Language of Invitation**

It is important to use invitational language when speaking to people who have a trauma. It may actually be a good rule of thumb for communication.

Invitational language invites a person into participation rather than commanding. Speaking from a place of invitation provides options and choice. Allowing people with trauma history to make choices about their own body is very important.

From a NAADAC webinar, [Trauma sensitive Mindfulness Practice as Recovery Maintenance](https://www.naadac.org/trauma-sensitive-mindfulness-practice-as-recovery-maintenance), presenter Angela Jones, shared information from the Trauma-Sensitive Treatment Protocols from the Trauma Center at Justice Resource Institute.

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| **The Language of Invitation** *An invitation rather than a requirement.*  |
| *When you are ready* | *If you like* |
| *As you like* |

This was adapted from Trauma Sensitive Yoga practices. The Trauma Center has a [DVD](http://www.traumacenter.org/products/yoga_DVD.php) on Trauma Sensitive Yoga that may be of interest to some.

**NAADAC Webinars**

**Choose one of these webinars to view**

NAADAC offers webinars, free for all to view. The link and description were taken directly from the NAADAC website.

* **Cultural Aspect of Trauma and Substance Use Disorder**

*This* [*webinar*](https://www.naadac.org/culture-trauma-SUDs-webinar) *will address clinically relevant variables of culture and gender and their implications in assessment and treatment planning. The webinar will provide insight for the clinician when working with a variance of cultures. Tools for assessment and treatment planning will be provided, as well as resources in the community and national resources.*

* **Intergenerational Trauma and the Healing Forest Model**

*This* [*webinar*](https://www.naadac.org/intergenerational-trauma-webinar) *will focus on culturally appropriate teachings that address concerns about issues that undermine the recovery process, such as intergenerational and historical trauma, dealing with shame and stigma, and solutions in dealing with these issues.*

**Self-Care**

An activity from Dr. Bessel van der Kolk’s book, The Body Keeps the Score, [Why You Should Write a Letter to Yourself Tonight.](https://www.naadac.org/intergenerational-trauma-webinar) After reading the web-article, write yourself a letter.

**Tools, Tips, and Resources**

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| **Interview** | **Bessel A. van der Kolk**, MD, is interviewed by Dr. Martin Korn regarding [PTSD after the World Trade Center Disaster](http://www.traumacenter.org/resources/bvdk_interview.php).  Dr. Van der Kolk also wrote the popular and informative book, The Body Keeps the Score. Visit his [website](http://besselvanderkolk.net/index.html) for information about his speaking engagements, scientific publications, research projects, and other interviews.  |
| **Video** | **David Emerson** created a 17-minute YouTube yoga practice that can be practiced in a chair. The video title is [Chair Yoga](https://www.youtube.com/watch?v=5f-LDmbygLw). |
| **Pdf** | **Patti Levin**, LICSW, PsyD, created a simple and beneficial pdf called [Common Responses to Trauma and Coping Strategies](http://www.traumacenter.org/resources/pdf_files/Common_responses.pdf). Dr. Levin’s pdf contains physical and emotional reactions to trauma, as well as helpful coping strategies.  |
| **Education** | **SAMHSA** created a resource for judges who interact with people who have trauma. The draft is called, [Essential Components of Trauma-Informed Judicial Practice](https://www.nasmhpd.org/sites/default/files/JudgesEssential_5%201%202013finaldraft.pdf).  |
| **Websites** | **SAMHSA’s** [Gains Center for Behavioral Health and Justice Transformation](https://www.samhsa.gov/gains-center) focuses on access to services for people involved in the justice system.  |
|  | [Sexual Abuse Resources](https://www.publichealth.org/resources/sexual-abuse/)  |
|  | [The Wounded Healer Journal](http://twhj.com/index.shtml)  |
| **Web Education** | **Jim Hopper’s** website article on [Sexual Assault and the Brain](http://www.jimhopper.com/sexual-assault-and-the-brain/).  |
| **Guide** | **SAMHSA’s** [Concept of Trauma and Guidance for a Trauma-Informed Approach](https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf) guide**.** |
| **Blog** | **Trauma Aware Care** [blog](http://www.traumaawarecare.com/blog).  |

As with all resources, before providing these to someone in need, ***ensure the resource is accurate and still active.***

**Glossary**

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| **ACE** | Adverse Childhood Experiences |
| **AJAM** | American Journal of Preventive Medicine |
| **ATRIUM** | Addiction and Trauma Recovery Integration Module |
| **Bessel Van der Kolk** |  |
| **CDC** | Centers for Disease Control |
| **Colin Ross** |  |
| **CRC** | Certified Rehabilitation Counselor |
| **David Emerson**  |  |
| **EMDR** | Eye Movement Desensitization and Reprocessing  |
| **Gabor Mate** |  |
| **Jim Hopper** |  |
| **Judith Herman** |  |
| **M-TREM** | Trauma Recovery and Empowerment Model  |
| **Melissa Engle** |  |
| **Mic Hunter** |  |
| **MOVA** | Massachusetts Office for Victim Assistance  |
| **NCC** | National Certified Counselor |
| **Pathology** | Diagnosing, implying something is wrong |
| **PhD** |  |
| **Pierre Janet** |  |
| **PTSD** |  |
| **Resilience (related to Trauma)** | Viewing the difficulties as a response to trauma.  |
| **Re-traumatize** |  |
| **SAMHSA** | Substance Abuse Mental Health Services Administration  |
| **Secondary Trauma** |  |
| **TAMAR** | Trauma, Addiction, Mental Health, and Recovery |
| **TARGET** | Trauma Affect Regulation: Guide for Education and Therapy |
| **Trauma** |  |
| **Trauma Specific Treatment** |  |
| **Trauma-Informed Care** |  |
| **TREM** | Trauma Recovery and Empowerment Model |
| **TSY** |  |

**Resources**

[American Red Cross](http://www.redcross.org/get-help/disaster-relief-and-recovery-services/recovering-emotionally)

800-985-5990

Text: TalkWithUs to 66746

[Center for Firefighter Behavioral Health](http://www.helping-heroes.org/)

David Baldwin’s [Trauma Information Page](http://www.trauma-pages.com/)

[Help Pro](https://www.helppro.com/HP/BasicSearch.aspx) Therapist Finder

[Homelessness Programs and Resources](https://www.samhsa.gov/homelessness-programs-resources)

[Jim Hopper’s website](http://www.jimhopper.com/) for research, education, and tools

[National Center for Post-Traumatic Stress Disorder](https://www.ptsd.va.gov/) through Veterans Affairs

[National Center for Victims of Crime](http://victimsofcrime.org/)

800- FYI-CALL (800-394-2255)

[National Child Traumatic Stress Network](https://www.nctsn.org/)

[National Domestic Violence Hotline](http://www.thehotline.org/)

800-799-SAFE (800-799-7233)

[National Sexual Assault Hotline](https://www.rainn.org/about-national-sexual-assault-telephone-hotline)

800-656-HOPE (800-656-4673)

[National Suicide Prevention Lifeline](https://suicidepreventionlifeline.org/)

800-273-TALK (800-273-8255)

[National Teen Dating Abuse Helpline](http://www.loveisrespect.org/)

866-331-9474

[The International Society for Traumatic Stress Studies](https://www.istss.org/)

[Trauma Center Trauma Sensitive Yoga](http://www.traumasensitiveyoga.com/)

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