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ΑΝΑΣΚΟΠΗΣΗ

# Τραύμα και εξαρτήσεις: Συνέπειες για τη φροντίδα

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**ΠΕΡΙΛΗΨΗ**
**Εισαγωγή:** Το τραύμα αποτελεί κοινό βίωμα σε πολλά άτομα που αντιμετωπίζουν προβλήματα εξάρτησης και στις οικογένειές τους, ενώ πρόσφατα έχει αναγνωριστεί ο κίνδυνος δευτερογενούς μετατραυματικής διαταραχής για τους επαγγελματίες που εργάζονται στον τομέα των εξαρτήσεων.
**Σκοπός:** Ο σκοπός της παρούσας εργασίας ήταν να ενισχύσει την κατανόηση της συνεχιζόμενης επίδρασης και του αντίκτυπου του τραύματος στη ζωή των εξαρτημένων ατόμων, των οικογενειών τους αλλά και των επαγγελματιών ψυχικής υγείας οι οποίοι επωμίζονται την ευθύνη της φροντίδας και της υποστήριξής τους..
**Μεθοδολογία:** Διεξήχθη ανασκόπηση της βιβλιογραφίας χρησιμοποιώντας συνδυασμούς με τις ακόλουθες λέξεις-κλειδιά: εξαρτήσεις, τραύμα, διαταραχή μετατραυματικού άγχους, οικογένειες, επαγγελματίες, φροντιστές, δευτερογενές μετατραυματικό άγχος. Η ανασκόπηση κάλυψε την περίοδο των τριών τελευταίων δεκαετιών, από το 1986 έως το 2016.
**Αποτελέσματα**: Υποστηρίζεται ότι για να καταφέρουν οι επαγγελματίες να βοηθήσουν τους ασθενείς να αποκαταστήσουν την αίσθηση σκοπού και νοήματος στη διαδικασία της ανάρρωσης, είναι κατ' αρχάς απαραίτητο να κατανοήσουν το βίωμα του ψυχικού πόνου των ατόμων και των οικογενειών που αντιμετωπίζουν τη διπλή ψυχική επιβάρυνση του τραύματος και της εξάρτησης.
**Συμπεράσματα**: Η κλινική εποπτεία μπορεί να συμβάλει ώστε οι επαγγελματίες ψυχικής υγείας να καλλιεργήσουν μια βαθύτερη κατανόηση των συναισθηματικών τους αντιδράσεων προς τους ασθενείς και τις οικογένειές τους αλλά και να προστατευθούν από τον κίνδυνο του δευτερογενούς μετατραυματικού άγχους.

**Λέξεις Κλειδιά**: Τραύμα, εξαρτήσεις, μετατραυματική διαταραχή άγχους, νοσηλευτές εξαρτημένων ατόμων, δευτερογενής μετατραυματική διαταραχή άγχους.

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REVIEW

# Trauma and addiction: Implications for practice

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**ABSTRACT**
**Introduction:** Trauma is common in many individuals who face addiction problems and their families while the risk of secondary traumatic stress disorder for professionals working in the addiction field has been recently recognized.
**Aim:** The aim of the present paper was to enhance understanding of the continuing effects of trauma and its impact in the lives of addicted individuals, their families and the mental health care professionals who strive to provide support and care for them.
**Methods:** A literature review was conducted employing variations of the following keywords: Addiction, trauma, post-traumatic stress disorder, families, professionals, service providers, drug and alcohol workers, secondary post-traumatic stress. The review covered the period of the last three decades, that is from 1986 to 2016.
**Results**: It is argued that for service providers to be able to help patients restore purpose and meaning in the recovery process, it is firstly imperative to be able to understand the nature of suffering experienced when individuals and families face the dual burden of trauma and addiction.
**Conclusions**: Clinical supervision may help mental health care professionals to work on a deeper understanding of their emotional responses to clients and their families and protect them from the risk of secondary traumatic stress.

**Keywords**: Trauma, addiction, post-traumatic stress disorder, nurses for addicted persons, secondary post-traumatic stress disorder.

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**INTRODUCTION**

Many people who face addiction problems have experienced trauma as children or adults.[1] Substance abuse is also related to higher rates of traumas as a result of the problem drug and alcohol users' lifestyle or the dangerous situations and accidents in which they are involved while under the influence.[2] Furthermore, individuals who face drug and alcohol problems and have experienced trauma may have worse treatment outcomes than those without histories of trauma.[3] Additionally many addicted clients carry the burden of histories of one or more traumas. More than fifty per cent of women seeking substance abuse treatment report one or more lifetime traumas.[4] Overall, it appears that trauma exposure is universal in this population and up to two-thirds of clients report current subclinical PTSD symptoms.[5-6] In comparison to individuals with a substance use disorder alone, those with comorbid PTSD report more extensive polydrug use, poorer social and occupational functioning, poorer physical and mental health, and higher rates of attempted suicide.[7]

Similarly with addicted individuals, members of their family report high rates of interpersonal loss and unresolved family grief transmitted through generations.[8-9] Families traumatic exposure to addiction leads to intense feelings of anger, guilt, ambivalence, pain and unresolved grief as well as overwhelming anxiety caused by the enormous responsibility of preventing death.[10-11] Orford et al.[12] describe the relative lack of forms of help designed for families who try to cope with the chronic problem of addiction. They conclude that addiction in the family is a major but neglected contributor to the global burden of adult ill-health.[12]

Finally, as regards the psychological impact of working in the addiction field, recent studies point that one in five addiction professionals report symptoms that meet the criteria for secondary traumatic stress disorder.[13-14] Although the true magnitude of secondary post-traumatic stress still remains unclear due to methodological limitations and differences in study designs and instruments employed, professional training, organizational cultures or organizational health care systems between countries, the risk of emotional distress implicated in working with traumatized clients has certainly been recognized.

The purpose of the present paper is to enhance understanding of the continuing effects of trauma and its impact in the lives of addicted individuals, their families and the mental health care professionals who strive to provide support and care for them.

Implications for practice are discussed in relation to the care of the addicted individual, and his/her family as well as the professionals' self-care.

**Diagnostic criteria of PTSD**

Traumatic experiences do not always result in long-term impairment for most individuals. Most people experience traumatic events across their lifespan and respond to them with resilience. Nonetheless, repetitive exposure to traumas can have a cumulative effect over one's lifetime. Some repeated traumas are sustained or chronic. Sustained trauma experiences such as ongoing sexual abuse, physical neglect, or emotional abuse may reduce resilience and the ability to adapt. According to the DSM-5[15], the following criteria apply in summary to adults, adolescents, and children older than 6 years if symptoms persist for month or more:

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways by directly experiencing, witnessing or learning about a traumatic event to a significant other or experiencing repeated or extreme exposure to aversive details of the traumatic event (s).

B. Intrusion symptoms associated with the traumatic event, (e.g. recurrent, involuntary, and intrusive distressing memories or dreams of the traumatic event, dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event were recurring, intense psychological distress or physiological reactions distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Avoidance of or efforts to avoid stimuli associated with the traumatic event (e.g. distressing memories, thoughts or external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings.

D. Negative alterations in cognitions and mood associated with the traumatic event (e.g. inability to remember an important aspect of the traumatic event or persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous,", feelings of detachment or estrangement from others).

E. Arousal symptoms (e.g. irritable behavior and angry outbursts, self-destructive behavior, hypervigilance, sleep disturbances).

**The lived experience of trauma in addicted individuals**

Substance abuse is one of the methods that traumatized people use in an attempt to regain emotional control, that is a means of self-medication.[16] Qualitative research on the lived experience of addiction enhances our understanding of the addicted person's



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reasons for abusing alcohol/drugs as well as on the process of recovery.[17-22] It appears that traumatic experiences may cause such profound suffering that a person will seek to handle the situation by means of substances. Gradually, the addicted individual watches himself deteriorate in all life aspects towards physical, social and moral degradation. Suffering is linked to the realization that physical sickness and psychological pain increase with each use and that each use is an escape from the guilt, shamefulness, and self-loathing set in motion by the previous one. The addicted person uses to save himself from the nightmare world of 'the horrors'[19] in a state of depression and despair, of powerlessness to break the circle. In essence he feels ambivalent, knowing the trouble the abuse causes, but at the same time the relief it provides.

Perceiving oneself as inferior to others and alienated from self and others, as well as being afraid of revealing oneself as vulnerable, are also described as motives for using drugs.[20] Feelings of being rejected and not worthy of being in communion with other people lock addicted individuals into loneliness. They tend to hide their vulnerability behind the façade of addiction, not only to others but also to themselves. They often seem to be unable to meet their inner self and trapped in emotions of anxiety, shame and guilt. Not recognizing their own feelings makes them feel strangers not only to others but also to themselves.

Shame is experienced as the result of stigma, being deceitful, being seen in a painfully diminished way as weak, dirty and helpless. In fact there seems to be a self-perpetuating chain of shame, guilt, isolation and addiction. Shame and guilt are lived as intensely painful emotions and they sometimes lead to a vicious circle of self-loathing, hopelessness and attempts to escape which may sometimes end up in a suicide attempt.[18-20] Overall qualitative studies into the traumatic experience of addiction point that addicted individual is constantly struggling to create meaning in a world where inner and outer experience do not match. Using constitutes a means of getting one's inner and outer world to match and thereby experience order, a struggle in a chaotic world of emotional extremes, that is feeling too much (overwhelmed) or too little (numb).

Finally, qualitative research on the experiences of women who abuse alcohol and/or drugs reveals themes of violence, abuse, male dominance, depression and isolation.[23-28] Stigmatization and being judged as immoral, inappropriate and/or unfeminine was linked to feelings of guilt, worthlessness and alienation. Such feelings often began in childhood since addicted women often described having grown up in chaotic family situations where emotional, physical and

sexual abuse were common while survival was a major concern. Sexual abuse was a devastating experience causing intense pain which was magnified by the fact that most women remained silent for fear that they would not be believed or that they would provoke the perpetrator's revenge. Overall, abused women felt betrayed, dirty or worthless. [27] Feelings of being unloved often turned into feelings of being unlovable.

**Trauma in families with addiction problems**

Family members frequently experience traumatic events in relation to addiction (e.g. angry outbursts, violent behavior, stigmatizing behaviors of others, intense anxiety related to the overwhelming task of preventing death, chronic poverty). [10-11] These repetitive experiences can increase the risk of secondary trauma and symptoms of mental illness among the family, heighten the risk for externalizing and internalizing behavior among children (e.g., bullying others, problems in social relationships, health-damaging behaviors), increase children's risk for developing posttraumatic stress later in life, and lead to a greater propensity for traumatic stress reactions across generations of the family. Overall, families' traumatic exposure to addiction leads to intense feelings of anger, guilt, ambivalence, pain and unresolved grief.[10-11]

As regards the children of parents with drug and alcohol problems, Kroll[29] described the 'don't talk' rule which encourages children from an early age, not to 'tell'. If children strive to talk about family realities, their perceptions and feelings are called into question. They know that family life revolves around something other than themselves but they are not allowed to know what it is. The "conspiracy of silence persists even when children have realized that drug or alcohol dependency is at the heart of their family dynamic. As a result children are isolated at home while secrecy, shame and fear cuts them off from the wider community. They may gradually become mistrustful of outsiders, reluctant to confide and fearful of others attempts to help or support them. Furthermore, difficulty in recognizing, differentiating and expressing feelings may lead to behavioral problems and some level of alexithymia.[30-31] They know they are well but they don't know how to express it. The longer the culture of denial and secrecy persists, the harder it is to penetrate. The experience of constantly feeling shut out and excluded, may contribute to the children's sense of being unwanted, rejected and unimportant. [32]

**Post-traumatic stress in professionals in the addiction field**

It appears that the process of recovery is more challenging when clients have histories



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of trauma. Recently, interest has recently been drawn on the pervasive effects that PTSD may have on professionals who try to address the needs of traumatized individuals.[33] As survivors reveal their trauma-related experiences and suffering to a professional, 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 'carries' the lived experience of trauma. A person facing both trauma and substance abuse problems may present a variety of other difficult life problems such as mental disorder, poverty, homelessness, increased risk of HIV, and lack of supportive networks. The experience of the therapeutic encounter with the client may indeed be challenging for many mental health care professionals. Clinicians often report intense emotional reactions which are defined as countertransference to addicted individuals, a term derived from psychodynamic approaches.[16,24] Countertranference refers to the emotional reaction of a mental health professional towards a client and may contain unconscious thoughts, feelings or attitudes towards him/her. Intense emotional experiences towards addicted individuals include hostile affective reactions, avoidance, punitive attitudes and 'defensive indifference' as professionals' reactions to being exposed to unaccustomed levels of anxiety in therapist-client interactions.[35-38]

Nonetheless, the range of secondary trauma reactions can be, but are not necessarily, similar to the reactions presented by clients who have experienced primary traumatic stress reactions.[33] Symptoms of secondary trauma may include physical or psychological reactions to traumatic memories clients have shared, avoidance behaviors during client interactions or when describing their emotions in clinical supervision, numbness, limited emotional expression, or diminished affect, somatic complaints, heightened arousal, including insomnia, negative thinking or depressed mood, and detachment from family, friends, and other supports.[16]

**Implications for practice**

**A. Caring for the addicted individual**

Caruth[39] describes trauma as an 'unclaimed' experience, an event 'experienced too soon, too unexpectedly, to be fully known and… therefore not available to consciousness until it imposes itself again, repeatedly, in the nightmares and repetitive actions of the survivor' (p.4). The experience of trauma actually leads to deep psychological injury at an unconscious level which entails loss of control, language, power and self. Trauma is a wound that "cries out", a silent wound which is articulated through re-enactments. As a result traumatized individuals are vulnerable to repeating past traumas and remain in a crisis without being able to regain control

over their current lives. Getting to 'know' their trauma overwhelms them emotionally to the extent of rendering its cognitive processing impossible. According to Caruth[39], recovery from trauma entails that it is spoken in all its horror and violation to someone who can listen to it without being overwhelmed. To integrate trauma into their lives, traumatized individuals must find language and symbols to express the frustrations, helplessness, disempowerment, and humiliation they suffered. Fragmentation caused by the rupture of trauma is healed through the construction of a narrative.

Hanninen and Koski-Jannes[18] analyzed addicted individuals' narratives of recovery. Their qualitative analysis revealed five different story type narratives: the AA story, the growth story, the co-dependence story, the love story and the mastery story. All of them helped to make the addiction and recovery understandable, they released the client from guilt and had a happy ending by which the values of the story were realized. Thereforem Hanninen and Koski-Jannes[18] emphasize that as there are several ways out of addictive behaviors there are also several ways to construe the change. People who try to quit addictive behaviors could be encouraged to make full use of the cultural stock of stories in creating an account that fits their own experience of defeating their particular addiction and come to terms with their past.

Similarly, Wiklund[21] described the lived experience of addiction and the patients' needs for forgiveness, acceptance and reconciliation. Feelings of being cut off from others and from life are a part of the addicted individual's suffering and bring forward needs for 'community' and 'attachment'. According to Bowlby[40] the need for attachment is a basic need in human survival. In relation to spiritual aspects of life it is linked to a need for a sense of communion with self, others and God. A caring relationship may provide the person with the safety needed so desperately. A secure attachment makes it possible for patients to explore themselves and their feelings. By reflecting on and remembering the suffering, meaning and purpose are restored while patients are helped to find new meanings and to (re)connect with themselves and with others through a story of reconciliation.

Reconciliation also constitutes a central issue in mental health care, palliative care and rehabilitation from chronic illness.[41-44] Delmar[43] describes reconciliation as a process of finding harmony with oneself as a move forward, towards acceptance. This process often entails a reevaluation of one's past identity and the construction of a new identity in a struggle to regain control over their current lives. Research findings involving



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patients recovering from psychosis demonstrate a process that start with improvement in their inner world of thoughts and feelings and result in reconciliation with the outer world around them.[41-42]

Finally, with regard to theories of nursing, the primary goals are to relieve suffering and instill hope[45-47]. Alleviation of suffering is accomplished through listening to and understanding the expressions of the patients' everyday needs.[48] Within the research field of dependency disorders, Wiklund[21] identified the patient's need to create a new frame of reference for interpreting of life, the need to experience coherence in life and a sense of restored dignity as well as the need for a sense of community, confirmation and acceptance. Forgiveness and reconciliation constitute central issues in promoting patient's recovery and helping them to ascribe new understanding and meaning to life and to what has happened earlier in life. Therefore, Wiklund[21] stresses that addiction nurses should accept addicted patients as unique and worthy human beings in an attempt to restore their sense of dignity. Acceptance may free addicted individuals from the intense fear of rejection and the chronic burden of stigma.

### B. Caring for the family

Several studies point to the necessity of the family's integration in the treatment of substance abuse, and describe the multiple benefits of such involvement. First, family members motivate substance abusers to enter treatment.[49] Second, they facilitate the maintenance of abstinence.[50] Third, family members are helped to effectively cope with their problems and improve the family's environment in which the addicted person is integrated after treatment.[51] Finally, the importance of family work is to some extent better recognized at a policy level.[52-53]

Nonetheless, despite the overwhelming evidence on the effectiveness of family interventions and the recognition of its importance at a policy level, family involvement in routine practice remains limited.[54-55] In spite of the wealth of information on the treatment of substance abuse, family involvement is not sufficiently described in the literature, clear directions about its planning are rarely offered and no consensus exists on a widely applicable model on family intervention in addictions. Additionally, there seems to be a relative lack of forms of help designed for affected family members in their own right.[12] Whenever parents and siblings are involved, they tend to be placed on the periphery of a comprehensive intervention.[56]

Lee, Christie, Copello, & Kellett[57] conducted semi-structured interviews with service providers regarding family involvement in alcohol treatment. Apart from barriers related to organization (e.g. lack of funding, time,

space, limited support from management) and families (diminished or no motivation for change, lack of/limited networks or substance misuse in the network) participants in their study reported also personal barriers related to their self-efficacy and the feelings they experienced during the encounter with families. Similarly, Copello, Templeton, Chohan, & McCarthy[58] described the dilemmas and complexities that determine whether family work is implemented in drug services concluding that there are still several misconceptions regarding family involvement. Their results were supported by Orr, Barbour, & Elliott[59] who concluded that by reinforcing stereotypes, perpetuating stigma and perhaps even fuelling self-fulfilling prophecies, the dominant narrative of 'family as part of the problem' inhibits family involvement. Overall, the three studies focusing on barriers and enablers on family work in the drug and alcohol field suggest that mental health professionals oftentimes remain reluctant and wary of working with families of addicted individuals.

With regards to the therapists' experiences in family therapy practice, Rober[60] discusses the vulnerability and negative emotions experienced by therapists working with family members whose conflicting interests and competing stories may hurt, blame, or confuse each other. Indeed, the importance of triadic interactions and triangulation issues have been thoroughly discussed in the family therapy field.[61] Whitaker [62] suggests that a triangle can be therapeutic when the therapist, who does not keep a 'neutral' stance in conflictual interactions, takes one's side and subsequently the other's, thus holding a flexible and somewhat unbiased attitude. Nonetheless, Dallos and Vetere[63] acknowledge how deeply threatening can be therapeutic work for both clients and family members in the drugs and alcohol field emphasizing the importance of establishing a trusting relationship between the client and an addiction key worker before the transition into family work. They describe family engagement as a process involving several professionals which is in line with the choices of some participants in the present study to refer parents to a colleague in order to address alliance issues in the therapist-client-parents triangle. Such suggestion could perhaps also be helpful to other professionals working in mental health or elderly care who strive to deal with tensions in the triadic encounter with caregivers and care-recipients.

Finally, Gabbard[64] stresses the need to avoid the siding up with the addicted person's vilification of his or her parents and to realize that the parent's view must be accepted with caution. Similarly, Vetere and Henley[65] describe in detail the complexity of engaging partners/family members of alcoholics into a



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community alcohol service using a case vignette approach. They also suggest the need for good interagency communication to avoid a therapeutic triangle becoming a 'sabotaging triangle'.

### C. Caring for the carer

Supporting addicted individuals in their struggle towards change and engaging family members in addiction treatment appears to be a challenging process for professionals. Clinical supervision has been suggested as a promising workforce development strategy within the addiction field.[16,34] Through supervision, professionals can be helped to step back from and reflect on their strong reactions to clients and their families. This may help them to gain a deeper understanding of the client-therapist-family communication and interaction and avoid becoming rigid in their thinking building a "wall" between themselves clients and their families by applying rules and theories. It may also allow the opportunity to gain invaluable insight into their contribution to the relationship they form with their clients and their families. Nonetheless, secondary traumatization is a significant organization issue for managers to address. Organizations can lessen the impact of the risk factors associated with working in the addiction field by addressing staff shortages, supporting ongoing professional training, providing regular clinical supervision, recognizing employees' efforts, and offering an empowering work environment in which clinicians share in the responsibility of making decisions and can offer input into clinical and program policies that affect their work lives.[16]

## CONCLUSIONS

The experience of trauma actually leads to deep psychological injury at an unconscious level which entails loss of control, language, power and self. By reflecting on and remembering the suffering, meaning and purpose are restored while patients are helped to find new meanings and to (re)connect with themselves and with others through a story of reconciliation. Nonetheless, the challenging nature of supporting addicted individuals in their struggle towards change and engaging family members in addiction treatment has to be recognized in order to protect professionals from secondary traumatic reactions. Clinical supervision may help mental health care professionals to gain a deeper understanding of the client-therapist-family communication and interaction and avoid becoming rigid in their thinking building a "wall" between themselves, the clients and their families by applying rules and theories.

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