

ADDICTIONS AND TRAUMA RECOVERY

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As we know from the work of Bessel van der Kolk, Onno van der Hart, and Bruce Perry, childhood trauma dramatically interferes with the body's ability to self-regulate both psychologically and somatically. This profound psychophysiological dysregulation in turn interferes with perception, cognition, affect tolerance, basic bodily functions such as digestion and respiration, hormonal and metabolic processes, and probably even immune function. Interpersonal, functional, and conceptual learning are compromised. Psychological development is delayed or distorted, and identity formation must proceed along the "fault lines" that result from dissociative defenses and compartmentalization.

Is it then any wonder that adult survivors of trauma become so remarkably adept at inventing **compensatory strategies aimed at self-regulation** long before they enter the doors of our offices, hospitals, and clinics? Some of these compensatory strategies incorporate lessons learned in the midst of trauma: self-injury and eating disorders capitalize on the patient's experience that the body can be used for and is nothing more than a vehicle for shifting or discharging tension. High-risk behaviors of all kinds fuel adrenaline and/or endorphin production to alleviate feeling states of fear and powerlessness and substitute feeling states of excitement or alertness or well-being. Dissociative symptoms and addictive behaviors are also ingenious ways of altering consciousness and changing psychophysiological experience. Thus, the chemical dependency could be viewed as "just another" attempt at self-regulation, not so terribly different from self-injury or any other type of trauma-related impulsive behavior. In this way of thinking about addiction in the context of Complex PTSD, we begin with two assumptions:

The first assumption is that any addictive behavior begins as a **SURVIVAL STRATEGY**: as a way to numb, wall off intrusive memories, self-soothe, increase hypervigilance, combat depression, or facilitate dissociating. The **ADDICTION** results from the fact that these psychoactive substances require **continual increases in dosage** to maintain the same self-medicating effect and eventually are needed just to ward off physical and emotional withdrawal. Thus, the substance use gradually acquires a life of its own that, over time, becomes increasingly disruptive to the patient's functioning until it is a **greater** threat to that individual's life than the symptoms it attempts to keep at bay. For this reason, the addiction issues must always be addressed concurrently in trauma

recovery because the substance abuse will consistently undermine all other treatments by impairing the patient's memory, perception, and judgment.

The second assumption of the model I use is that we must understand **HOW** the addictive substances have helped the trauma patient to survive: that is, which trauma symptoms has she been attempting to treat through her drinking and drugging? Through her eating disorder or sexually addictive behavior? We need to know this information for a number of reasons:

- First, we need to know because these are precisely the symptoms that will **exacerbate** once the patient becomes sober or abstinent.
- We need to know, too, so that we can begin to **anticipate** other coping strategies she will need in order to deal with those symptoms as they erupt and threaten to overwhelm her.
- We need to be able to **predict** when and how the symptoms may potentially trigger a substance relapse so that we can help her strengthen the addictions recovery program she has chosen.
- And, finally, we need to know so that we can help the survivor appreciate her valiant attempts to cope with the effects of the abuse and, from that recognition, develop sufficient **compassion and self-respect** to counteract the shame and guilt that is the inevitable byproduct of her addictions and trauma history.

So, **which** PTSD symptoms should we expect the substance abuse to have addressed? First, we need to look for those symptoms we would **expect** to be problematic for any trauma survivor. Then we can think about the particular psychoactive effects of different types of drugs and “match” these effects to the appropriate symptoms.

For these purposes, I divide the most common trauma symptoms into four broad categories:

- **Re-enactment Symptoms:** this category includes attraction to dangerous situations, risk-taking, sexual acting-out, suicidality, self-harm, attraction to abusive relationships, and many types of self-sabotage. Drugs such as alcohol and cocaine facilitate or mimic re-enactment symptoms, especially when the drug use itself involves secrecy, danger, shame, and “getting away with it.” These substances decrease shame and guilt, and they also decrease the likelihood of the trauma memories breaking through by ensuring that the patient is on an endorphin or adrenaline “high” much of the time. Sexually addictive behavior not only produces a high but also often involves re-enactment of sexuality as unsafe.

- **Persistent expectation of danger:** alcohol and marijuana are particularly useful substances for **reducing** hypervigilance or reducing the chronic fear of danger to the point that the patient can sleep or go to work or maintain relationships or leave the house or be in a social situation without panic or paranoia. Cocaine and speed, on the other hand, are useful for **increasing** hypervigilance and feelings of power and control, thereby decreasing anxiety in the exactly opposite way.
- **Hyperarousal Symptoms:** because trauma survivors are continually at risk to be intruded upon by **memory equivalents** (such as images and flashbacks, nightmares, body memories, olfactory and tactile memories, and “feeling flashbacks”), the hyperarousal symptoms are often the ones about which the patient most frequently complains. They are also the most overwhelming and potentially de-stabilizing, and they are the most likely of all the symptoms to trigger drug and alcohol relapses. Typically, the trauma patient will have used alcohol and marijuana to induce relaxation and numbing effects or to act as a “chemical barrier” or to facilitate her ability to dissociate. Restricting food intake and overeating also produce these same effects. Cocaine may also have been needed, in conjunction with the alcohol, to increase hypervigilance as he or she got drunker and drunker, or perhaps the patient relied on adrenaline triggered by high-risk behavior and/or cutting to increase arousal. Heroin and the opiates are probably **the** most effective drugs for keeping intrusive symptoms at bay and for dampening rage and aggression. It should not surprise us then that so many Vietnam vets became addicted to those very drugs.
- **Numbing or Hypoarousal Symptoms:** in this category, we would include the dissociative symptoms because of their role in helping trauma patients to get sufficient distance from the intrusive symptoms. While marijuana, heroin, under- or over-eating **induce** numbing effects, speed, cocaine, and even self-injury **counteract** numbing, not just by increasing hypervigilance but also by increasing the sense of well-being and the feelings of being truly “alive” which are so compromised by the numbing symptoms. Because depressive numbing often leads to suicidal despair or to self-injury, the use of stimulants to “fight” numbing symptoms may have been a paradoxical way of trying to stay safe. Alcohol, of course, is the most versatile of all drugs in self-medicating the numbing symptoms because, at different “dosages,” it can help to mitigate numbing **or** to induce it.

When my patient, “Anna,” finally bottomed out at age 26, she had no idea of the many ways her alcoholism had been helping her to cope with her trauma symptoms, her dissociativeness, and her psychosocial isolation. As she struggled to stay sober, it became apparent that the alcohol had served an array of functions:

- For example, she had been able to tolerate her isolation because she could always go to any one of a number of bars that catered to young adult professionals and feel a sense of being amongst “family.” She knew all the bartenders, all the regulars, all the special nights at each bar.
- The alcohol also medicated her chronic anxiety by day and allowed her to “sleep” at night (by virtue of inducing black-outs). She never had intrusive memories or flashbacks or nightmares until she became sober.
- Under the influence of alcohol, her self-esteem got an artificial boost, and her shame and self-hatred lessened. She felt attractive, amusing, and intelligent; although she believed herself to be “trailer park trash,” her drinking life at trendy bars in the company of other young, upwardly mobile professionals allowed her to fantasize being “one of them.”
- Nightly drinking binges also allowed her to “forget” a number of pressing problems in her life which ultimately threatened her safety and stability, most notably how deeply in debt she was. Anxiety about her precarious financial situation or awareness of how suicidal she often felt could be wiped away by a few glasses of wine.
- Last but not least, most of the time, her alcohol use enabled her to keep under wraps angry, belligerent impulses that often undermined her social and professional credibility. And, concurrently, alcohol use also facilitated the over-use of her ability to function on autopilot because she could “black out” intrusive anxiety and shame and vulnerability.

Thus, long before substance use becomes abuse, a trauma survivor such as Anna learns to “successfully” control her symptoms using her drugs of choice so that she can function in the world. I use the term “successfully” because, to the extent that using drugs and alcohol to manage trauma symptoms “works” for the survivor, it may prevent suicidality, loss of functioning, social withdrawal, and a host of other problems common to those who have been traumatized. Whatever the precipitant that brings this patient to our offices, she will come with some strengths or skills which would not have been possible for her to have developed without having used drugs and alcohol to help her stay stable—or **stabler**. (For example, Anna was 26; after a brief decompensation at age 14, she had been able to successfully delay the disruptive effects of her trauma history until she had finished high school, gone to college for two years, and been able to advance in her career.)

It is the therapist's job to remember to look for these strengths and to point them out to the patient at a time when she is feeling a profound sense of shame and failure. We also must not forget that one of the greatest benefits for her in the use and abuse of substances to control her symptoms was that **she did not need to depend on anyone**: she did not need to trust **or** to ask for help **or** to feel needy **or** to feel abandoned because help was not forthcoming. **She was in control**. Our work must be to help her regain a sense of being in control and able to master her symptoms—this time through the acquisition of new skills and inner resources.

But HOW do we do this?

The answer is that we do it **the same way** we would with any trauma survivor who presents in a dysregulated state with self-destructive and/or therapy-destructive symptoms and behavior. Whatever our particular training or theoretical orientation, what most of us do is very similar. We offer:

- a respectful, compassionate, safe arena for doing the work, one that avoids pathologizing on the one hand and enabling on the other
- a psychoeducational crash course in understanding the link between trauma and addictions
- and a re-reframing of symptoms in such a way as to promote ego strengthening and integration of behavior, affect, sensation, and knowledge

Psychoeducationally, we need to make a compelling case that, not only is bodily and psychological safety a prerequisite for trauma recovery but that **sobriety** and **safety** are one and the same—that the patient cannot keep herself safe if she is not sober and that she cannot stay sober without keeping herself safe and stable. This must be the frame for treatment, encompassing both the first stages of recovery from trauma (Judy Herman's stage of safety and stabilization) and the first stage of recovery from substance abuse (sobriety or abstinence).

We need to explain in detail over again and over again the following foundation concepts:

- **WHY** sobriety is a prerequisite for safety and self-care
- **HOW** substances which were once life-saving for her have become so dangerous **now**
- **WHY** having an addictions recovery program is essential in the battle against impulsivity and the “quick fix”
- **HOW** the mind-altering properties of her drugs of choice now impair her ability to recover from the trauma
- **HOW** the trauma symptoms equally impair her ability to stay clean and sober

This psychoeducational piece requires us to be aware of all the positive aspects of the culture of addiction: for example, how the effects of psychoactive drugs on memory are dose-related and selective so that the patient's recall of a bad drug experience may be more impaired than her recall of the positive feelings she had leading up to it, **or** the "bad" aspects of the substance abuse may seem cognitively divorced from the actual drinking and drugging as if there is no connection (this is a common occurrence when the negative consequences are related to "coming down" or to a DWI or to getting into trouble at work for coming late or being absent). We need to be aware of the sense of support or unconditional acceptance the survivor experienced in the company of her drinking and drugging friends, the sense of being attractive or powerful, the funny things that happened, the euphoria. We need to be **curious** as we explore her drug history for information about the role of the addiction in her survival. What was the timing of her early attraction to drugs in terms of its role as a "solution" to traumatic material impacting her experience: did she begin to misuse drugs at puberty? Or after she was raped in college? Or when her first child was born? Or after her discovery that her husband was having an affair?

How did her drug use help her to cope at that earlier time? How did she respond to changing needs to cope more or to cope differently by changing the pattern of her drug use? Did she have to "use" more often? Or change her substances of choice? Did she begin to act out addictively when chemically disinhibited? (For example, by cutting or engaging in compulsive sexual behavior) When did her addictions begin to **negatively** affect her ability to cope? What did she do then? At each step of the way, it is important to validate that her choices of behavior were attempts to stay in control of these powerful forces within her, even if those attempts were not entirely successful—even if the end result was not a "pretty sight."

Once we have fully grasped the "contribution" the addiction has made at different points in the patient's trauma history and have been able to describe that to her just the way we would describe the role of an alter or ego state, the next most important psychoeducational input we can provide is to predict what is known as the "Abstinence/Relapse Cycle." We need to warn the patient that sobriety or abstinence often precipitates a whole series of new crises and new symptoms because she now will be totally without the "chemical" treatment she has been using to combat her symptoms. What will likely begin to happen very early and repeatedly is that each time she becomes sober, her PTSD symptoms will exacerbate. And each time her PTSD symptoms exacerbate, she will be at risk for an addictions relapse.

The Abstinence/Relapse Cycle can be particularly demoralizing when the patient is genuinely attempting to abstain from substances or when she hears other patients in her therapy group or AA meeting talk about feeling "better" or even euphoric (the proverbial "pink cloud") after they become sober. Unfortunately, **she** finds that sobriety or abstinence does not seem to diminish **her** symptoms; instead, abstinence exacerbates them. Think of this from the patient's point of view: her friends, family and therapist have all told her that, in order to recover, she has to give up her most trustworthy survival

strategy. Then, instead of feeling better, she finds herself feeling **much** worse. The cycle is then in motion: abstinence is followed by an increase in PTSD symptoms which in turn trigger an addiction relapse; each relapse is followed by another attempt at sobriety followed by more depression or anxiety or intrusive symptoms leading to another relapse. Gradually, the relapses tend to become longer; AA attendance dwindles; there may be increased suicidality or acting out. Both patient and therapist can become angry and discouraged: the patient may feel misled, and the therapist may feel that the patient is simply not trying hard enough.

With Dissociative Identity Disorder patients, there is another twist to the Abstinence/Relapse Cycle provided by the ability to split and compartmentalize. Often, the abstinence behavior is important to one alter or a particular group of alters, while the relapses and acting out are the response of another part or group of parts. The dissociative symptoms also allow for a greater likelihood of the patient “keeping secrets from herself,” e.g., when the addict alter goes out drinking after the sober alters have come home from an AA meeting. Although this phenomenon will clearly complicate the challenge of staying sober, it can also be used to advantage! For example, if the sober alter or ashamed child alters are demoralized by the relapses, it can be de-shaming and ego-strengthening to locate the addictive behavior in a separate part of the Self. Knowing that the addict alter is, for example, an overwhelmed, desperate teenager can increase feelings of compassion in the face of yet another relapse. Older and wiser selves can be asked to work with the addict as inner co-therapists. Perhaps they could even “take” the addict alter to a Young People’s AA meeting! When the dissociativeness can be **capitalized on** by displacing “bad behavior” onto one or more addict alters and locating the wish for sobriety or the compassion for self or the ability to make good judgments onto the sober alters, the Adult Self or host can more easily comprehend her incredibly confusing array of internal conflicts and pressures.

As the patient becomes better educated about the Abstinence/Relapse Cycle, a number of therapeutic opportunities open up. Therapist and patient can begin to anticipate and predict the next relapse. Not only does anticipation help by offering a skill-building opportunity; it also helps by virtue of increasing the patient’s sense of control over the process. She may be powerless to prevent cravings and impulses, but she does have the “power” to be one step ahead of a relapse or to predict it even if she cannot stop it. If the addictive behavior “belongs to” or is located in a particular part of self, then the anticipatory work can include empathizing and working with that part around what it needs to cope with the pain in some other ways. The parts who are committed to sobriety can offer their “experience, strength, and hope” to the addict alter, or they can provide the necessary soothing and support to diminish some of the impulsivity, just as they would to anyone in their 12-step program. Therapist and patient (including relevant alters) can develop Trigger Logs which document both triggers of PTSD symptoms and triggers of drug-seeking behavior. Then the anticipatory work can be expanded to include preparation for dealing with the most common triggers. For example, my patient Anna had to walk past a liquor store to get to her apartment from the subway. One day, after a particularly tiring work schedule and a stressful encounter with her boss, she found herself wandering around this liquor store with a bottle of wine in her

hand. Looking back, we could identify a number of triggers: first, there was fatigue and hunger (a trigger for both addictive and PTSD symptoms); secondly, an authority figure had treated her unfairly (a PTSD trigger); third, instead of going to her regular AA meeting, she had decided that she was too tired and needed to go home (this cost her a needed coping support); and last, she had “forgotten” that the walk to her apartment required passing that very triggering liquor store. Notice, too, that she had dissociated at some point between leaving work and entering the liquor store. Notice that the triggers included not only interpersonal events and visual cues but also somatic states. It is extremely important to help patients learn that even somatic and affective states can be triggers, not just “people, places and things.” In AA, alcoholics are taught the acronym “**HALT**” (**H**ungry-**A**ngry-**L**onely-**T**ired) to help them remember to look **inside** for potential triggers, as well as outside.

Another rich area for work on anticipating and preparing for the Abstinence/Relapse Cycle involves re-framing the relapse as a “Golden Opportunity” rather than as a failure or “slip.” When we use the **opportunity** of the relapse to look at what triggered it and to develop new strategies for dealing with those particular triggers, then the next period of sobriety will be a little more stable, and so will the next and the next. If we clearly define a relapse as simply part of the cycle, just as useful as the periods of abstinence, then we are teaching the survivor to think about recovery as a **process**, and that will be invaluable to her throughout both her trauma and addictions recoveries. The lesson is that sobriety, safety, and stability go hand-in-hand. Following a substance relapse or a safety “relapse,” we help the patient go back to the moments or hours beforehand and mindfully notice the triggers: the symptoms, the stresses, the somatic states, the events which set the relapse in motion. Then we ask her to think about what “early warning signs” there might have been that she could not see at the time: for example, skipping an AA meeting, not taking her medication, isolating socially, not telling the therapist about her increased level of impulsivity, losing time, find drug paraphernalia she thought she had thrown out, calling old friends from her drinking and drugging days. “Early warning signs” can be obvious, like those I just listed, or extraordinarily subtle, such as going to meetings but using them to focus negatively on how different she is from all those alcoholics or on how irritating she finds the focus on spirituality. Another subtle early warning sign might be deciding not to answer the phone, or “forgetting” a therapy appointment, or having difficulty switching out of a depressed, hopeless mood, or “not bothering” to use all of her anticipatory skills and plans. Once we have identified the early warning signs, then we examine everything that happened **during** and **after** the relapse in order to see if there was anything she could have done at any point that would have made a positive difference.

The focus of the work is always on anticipating, managing, and coping. Each setback is clearly and positively labeled as a “learning opportunity” or a “message,” thereby imparting a meaning-making component to it. As much as possible, the emphasis is on an immediate return to safety and sobriety, followed by an attempt to capitalize on the learning potential by deciphering the “message” of the relapse.

- Did the patient ignore symptoms, triggers, or early warning signs?

- Did she neglect to ask for help when she needed it?
- Does she not have enough support?
- Or does she need to work on issues of trust so that she can better use the supports available to her?
- Does she avoid or devalue AA meetings?
- Did she minimize the seriousness of her distress and try to “white-knuckle” it?
- Did she distance from or abandon the addict alter at a time of stress?

The “learning opportunity” not only includes the potential to foster some new skills and resources; it also provides a welcome place to help the patient develop new cognitive schemas which will **increase** her resilience and **decrease** her self-loathing, schemas such as “No one is perfect,” or “Progress, not perfection.” Sometimes the lesson of a relapse is that the **trauma symptoms** need more aggressive treatment: for example, the patient is having increased panic symptoms each time she is sober for more than a few weeks, and she needs to focus on using breathing techniques or safe place imagery to alleviate the anxiety. Sometimes the learning is that **sobriety** needs to be addressed more vigorously: the patient has no sobriety program and has inadequate support for staying sober because she resists going to AA meetings. (Perhaps she needs to find a small women’s meeting group, or a meeting for gays and lesbians only, or a noon downtown meeting that attracts young, educated professionals with whom she feels proud instead of ashamed to be associated. Perhaps she needs to find an AA sponsor to whom she can relate, even if she has difficulty relating to the group as a whole or to the program.) Sometimes the learning is that the **interaction between trauma and addictions work** needs to be addressed. For example, the patient is made anxious by AA meetings because the large groups or the number of men or the rhetoric trigger traumatic memories. She may need to work on techniques for calming the body, anticipating triggers, differentiating facts from feelings. Or she may need to plan some new coping efforts (such as going with a friend, sitting near the door, coming late and leaving early). Or she may have to work on identifying the unwelcome “side effects” of AA and on anticipating them the way she anticipates and deals with the side effects of medication or bodywork or even talking therapy.

The emphasis is always on the process, in contrast to the “quick fix” coping approach learned by the trauma survivor in childhood and reinforced by the addiction. The “quick fix” was necessary for her to survive: in a life-or-death situation, the child victim did not have the luxury of time to experiment with different alternatives. She had to react immediately and even impulsively to forestall physical and psychological annihilation. As an adult, her addictive behavior or drug of choice played a similar role in providing a quick and effective “fix” for her. Now she has an opportunity to learn a healthier way, but she will have to battle the need for a “quick fix” solution. As the therapist and patient attempt to develop alternative coping strategies which can adequately address her trauma symptoms, they will immediately come up against two harsh realities: first, the patient does not have much of a repertoire of alternative coping behaviors upon which to draw; and secondly, that the alternatives must become as automatic as her more familiar addictive survival strategies in order to be effective.

In this effort, it is crucial for the therapist to acknowledge that **nothing** you can teach or give her, **nothing** she can learn in AA or in her early sobriety group, **nothing** even the psychopharmacologist can offer will hold a candle to the immediately and almost completely effective relief she once experienced when her drinking and drugging “worked” to control her symptoms. If we do not acknowledge how good the quick fix felt when it worked, we will not be able to “sell” the patient the much more difficult but ultimately safer coping strategies which we have to offer. If we do not present a convincing argument that her addictive behavior began as an attempt at mastery, not self-destruction, we will have a harder time helping her to believe that she has the resources within her to now recover from the trauma without the “help” of the addiction.

Again, notice the themes of a trauma-oriented model of treatment:

- **“knowledge is power”**: using psychoeducation to facilitate mindful, non-judgmental attention to symptoms and behavior
- **“boring the patient into health”**: by minute and mindful attention to any breaks in safety and self-care
- **re-framing symptoms and behavior**, no matter how impulsive and self-destructive, in such a way that they can be “owned” and thus integrated with constructive, wise and thoughtful states of mind
- **“remembering is not recovering”**: keeping in mind that the goal of “trauma work” is not to remember what happened but to be able to live today and to tolerate the ups and downs of a normal life in spite of what has happened

As the Abstinence/Relapse Cycle is slowly brought under control, addictions recovery actually can **strengthen** trauma recovery. The process of learning how to stay sober and abstinent in a state of psychophysiological dysregulation is a process that brings with it a powerful sense of mastery, of triumph over what once felt impossible. That experience can become a template for the even more difficult challenges of trauma recovery: the survivor may have been helpless to prevent what happened in the past, but she is not helpless when it comes to forging a healthy present.

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