Building Resiliency in those with co-occurring disorders

A strengths- based approach

GOAL

Improve the ability of those working with individuals with dual diagnoses to utilize trauma-informed care principles in their work with a focus on building resiliency using strength-based approaches

Objectives:

1. Understand the relationship between substance use and mental health disorders

2. Understand the impact of trauma on the development of SUD & related disorders

3. Shift Conceptualizations : “what happened to you” rather than “what is wrong with you”

4. Building Resiliency using a Trauma-Informed and Strengths-based perspective

Co-Occurring Disorders

- Co-morbidity of substance use disorder and another mental health disorder: the disorders CO-EXIST and INTERACT.

- Individuals with a SUD are more that twice as likely to have another mental health disorder, more for adolescents.

- Some of the most common mental health disorders found in those with SUD include:
  - Mood Disorders: 32% (56% for bipolar disorder)
  - Anxiety Disorders: 30% (50 % for PTSD)
  - Personality Disorders: 44.3% (75% for BPD, 74% APD)
  - Thought Disorders: 41%

www.ncbi.nlm.nih.gov

Why do these disorders often co-occur?

- **Common Risk Factors**
  - Genetic and epigenetic vulnerabilities
  - Brain region involvement
  - Environmental influences: stress and PTSD

- **Another mental illnesses can contribute to SUD.**
  - Self-medication: people may use substances to relieve symptoms of mental illness.

- **Substance use can contribute to the development of mental illness.**
  - Substance use may change the brain and environment in ways that make a person more likely to develop a mental illness.

  - www.drugabuse.gov/commoncomorbidities

Treatment for two entwined problems

- Integrated treatment approaches are highly recommended.

- In the US, according to NIDA, about 18% of SUD treatment programs and 9% of mental health treatment organizations have the capacity to serve those with co-occurring disorders.
- Symptoms of substance abuse can mask symptoms of mental illness, and symptoms of mental illness can be confused with symptoms of addiction.
- Symptoms of mental illness may not be accurately diagnosed until a period of sobriety.
- Screening for both is essential. “Is this working?”

Research on Co-Occurring Disorders and Trauma for Women

- Newmann and Sallmann (2004) found that 95.7% of women who utilized both substance abuse treatment and mental health systems, 89.6% who used mental health only, and 82.5% who used substance abuse only, all reporting histories of abuse.

- SAMHSA's WCDVS(2005) found that participants reported high incidences of recurring abuse beginning in early childhood. More than 91% of participants reported a history of physical abuse; 90% reported sexual abuse within their lifetime; 72.5% had been forced to have sex; and 52.5% had exchanged money, drugs, or material goods for sex. (Becker et al., 2005).

- Gatz et al. also looked at the WCDVS (2005) and found that most women reported abuse to have occurred prior to substance abuse or mental health issues. Most women reported multiple attempts at treatment for their substance abuse and mental health issues and multiple unsuccessful experiences.

Research Outcomes for Youth

- Jaycox et al. (2004) examined trauma exposure, posttraumatic stress disorder, and psychosocial functioning among adolescents 14-21 entering a substance abuse treatment facility. Nearly three quarters (73%) had experienced at least one of the traumatic events in the survey prior to admission, most of the traumas reported were severe, and 29% of the adolescents met criteria for a current PTSD diagnosis.

- Ballon et al. (2001) assessed 287 male and female youth aged 14 to 24 in substance abuse treatment and found that 50% of females and 10% of males had a history of sexual abuse. In addition, 50% of females and 26% of males had a history of physical abuse. The percentages present in this population for occurrence of physical and sexual abuse are more than double the rate of occurrence for the general population.

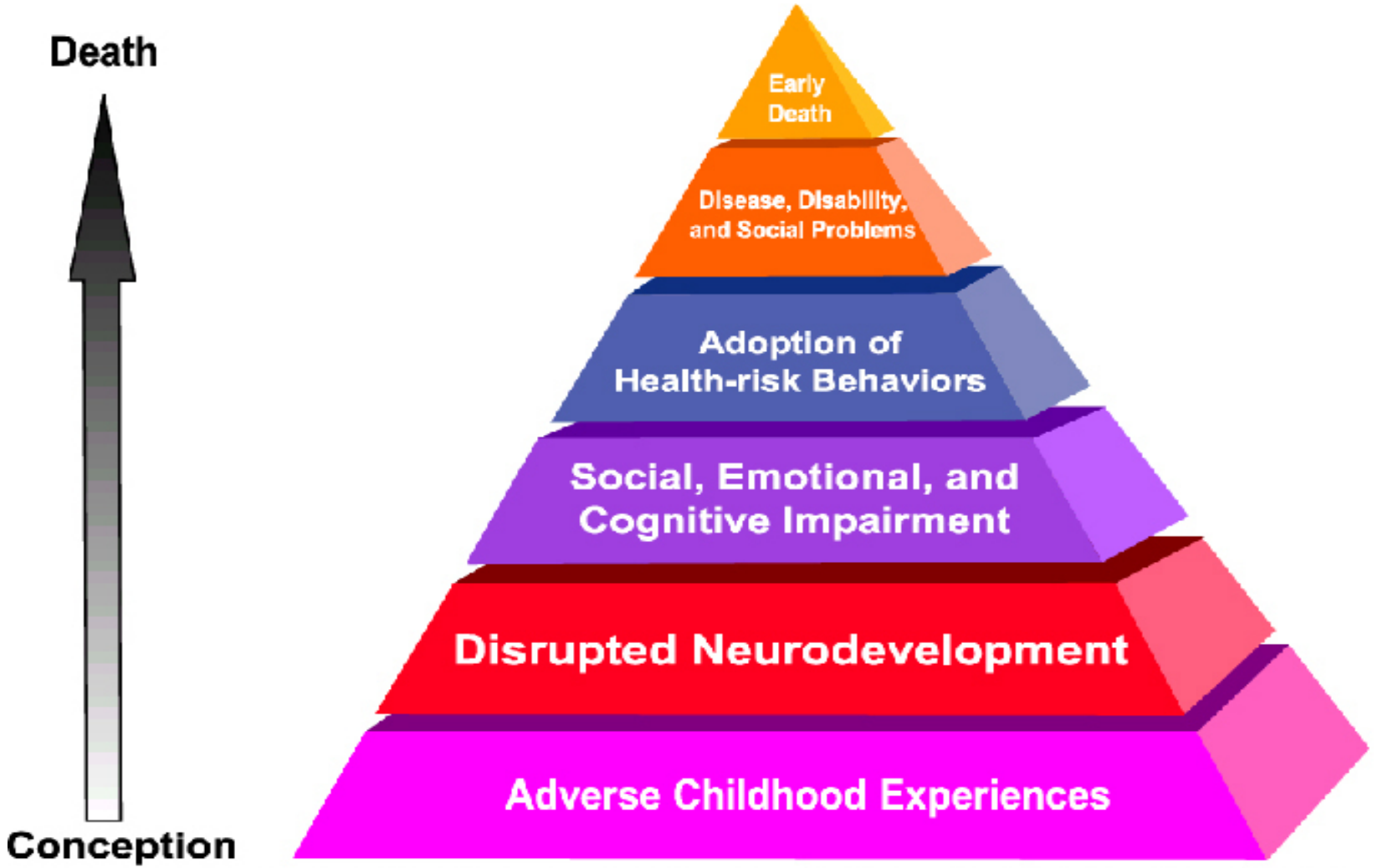
- Significant relationships found between childhood abuse and neglect on later substance abuse and psychological distress, particularly coping styles, in adulthood. Factors such as avoidant coping, shame, self blame, interpersonal difficulties, or attachment insecurity were all offered as important to consider when working with substance abusing adults who experienced childhood trauma (Min et al., 2007; Whiffen & MacIntosh, 2005).

Trauma in Vulnerable Populations

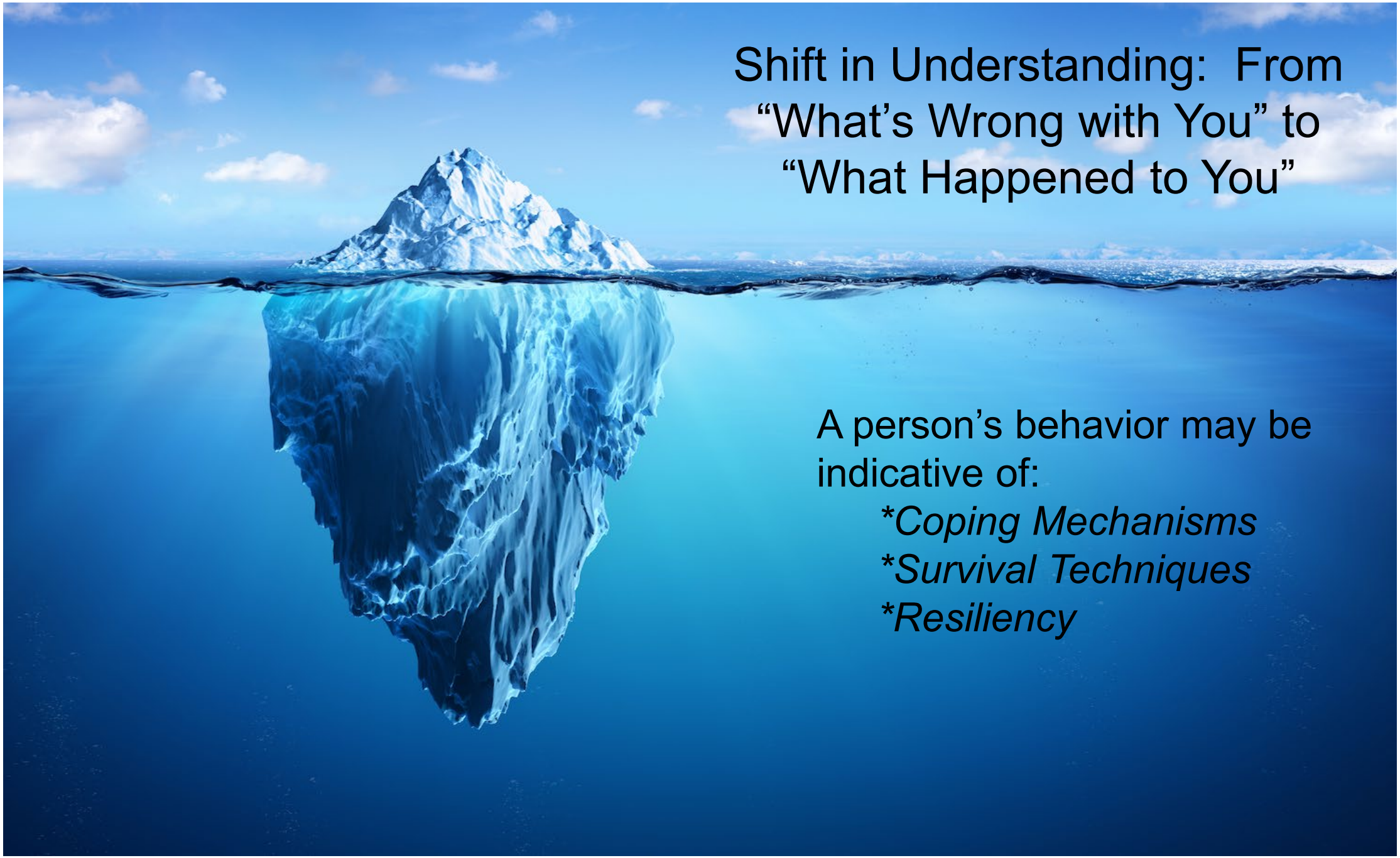
- Majority of adults diagnosed with **Borderline Personality Disorder (81%)** were sexually or physically abused as children.

- **45% of individuals in state and local prisons** have a mental health problem comorbid with a substance use disorder.

- Shafer (2003) estimates hidden comorbidity in the elderly, **25-50% of elderly suicide victims** used alcohol prior to their deaths.



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan



Shift in Understanding: From "What's Wrong with You" to "What Happened to You"

A person's behavior may be indicative of:

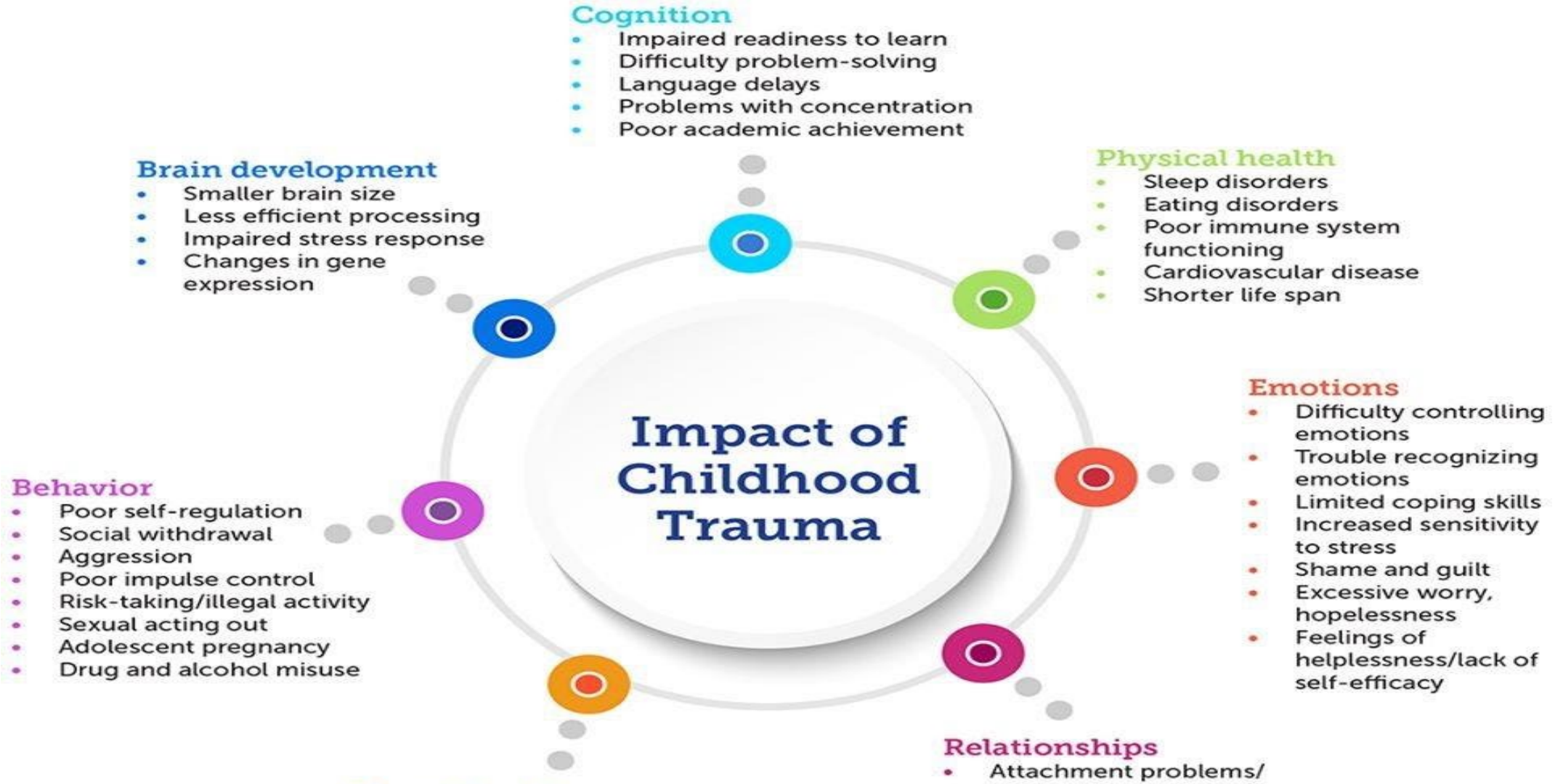
- *Coping Mechanisms*
- *Survival Techniques*
- *Resiliency*

What is mental illness?

"Mainstream" understandings of mental illness position the individual as someone who is disordered, ill or distressed; the problem is located in the individual.

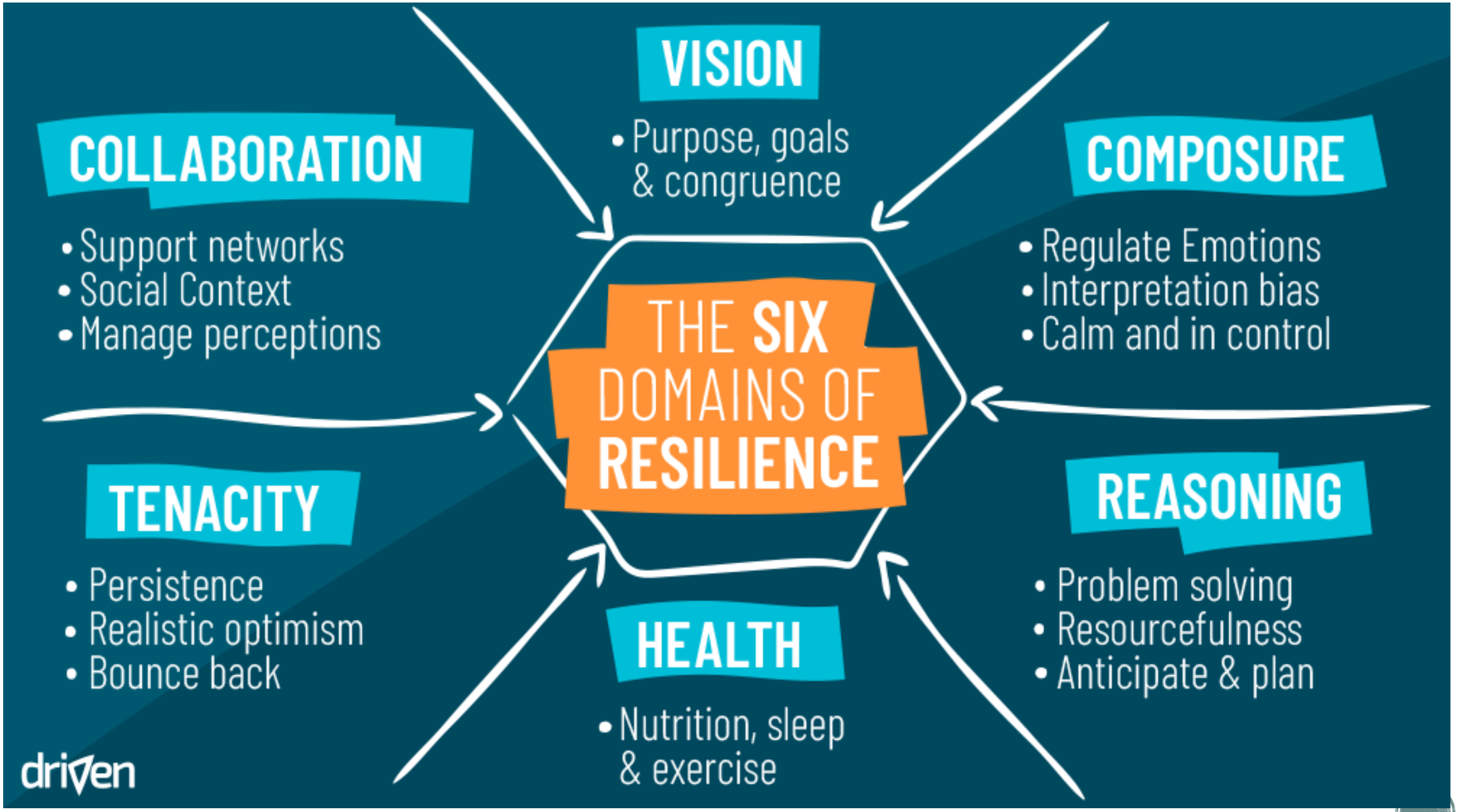
As Smail (1987) states, clients of the mental health system are *'people upon who the world has impinged in any of a variety of painful ways. They are less people with whom anything is wrong than people who have suffered wrong.'*

Impact of Childhood Trauma



As a provider, in whatever our capacity, we get the opportunity to model that which we hope to assist our client's in developing *within the context of the relationship with the client*.

SHOWING works better than TELLING.


VISION
• Purpose, goals & congruence
COLLABORATION
• Support networks
• Social Context
• Manage perceptions
COMPOSURE
• Regulate Emotions
• Interpretation bias
• Calm and in control
THE SIX DOMAINS OF RESILIENCE
TENACITY
• Persistence
• Realistic optimism
• Bounce back
REASONING
• Problem solving
• Resourcefulness
• Anticipate & plan
HEALTH
• Nutrition, sleep & exercise
driven

Health:

Trauma impacts sleeping and eating patterns, poor immune function, lifespan health impacts.

Build resilience through attending to health, acknowledging its importance and modeling an attention to self-care.

Check in around these: if an individual is hungry, unclean, sick, tired, how does that impact them?

Reasoning

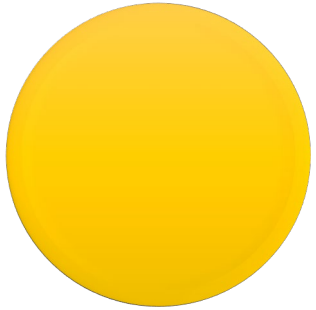
- Developmental trauma is disorganized and disjointed- impacts efficiency of processing, memory, stress-response.
- Impacts ability to learn, concentrate, plan, and problem solve.

- Resourcefulness
- Problem Solving
- Anticipating and Planning

E- every patient
S- provide social support
C- give choices
A- anticipate what will happen next
P- help clients plan and organize (realistically)
E- every time (over and over and over)

Building Composure

trauma impacts self-regulation, aggression, impulse control, identifying emotion, understanding social cues



CALM AND CONTROL

REGULATE EMOTIONS

INTERPRET BIAS

- S- SLOW DOWN
- T- Take a step back, breathe
- E- Empathy statement
- P- Practice self-regulation
- S- Stay connected, check in later

Help in Calming the Fight/Flight/Freeze instead of engaging it

- Slowing down moves us away from crisis and into calm.
  ("I'm never coming back here. Everyone here is so rude")

- If YOU are feeling anxious, irritated, escalated, so is the client.

- We are the ones with the skills of recognizing the emotion and stepping outside of it to avert crisis, escalation.

- Once calm, offer warmth and discussion on distorted perceptions, perhaps between BOTH of you (we are not <u>always</u> right)

TENACITY

"the quality or act of being very determined"

Trauma can create a sensitivity to stress and worry, and lack of agency, feelings of helplessness.

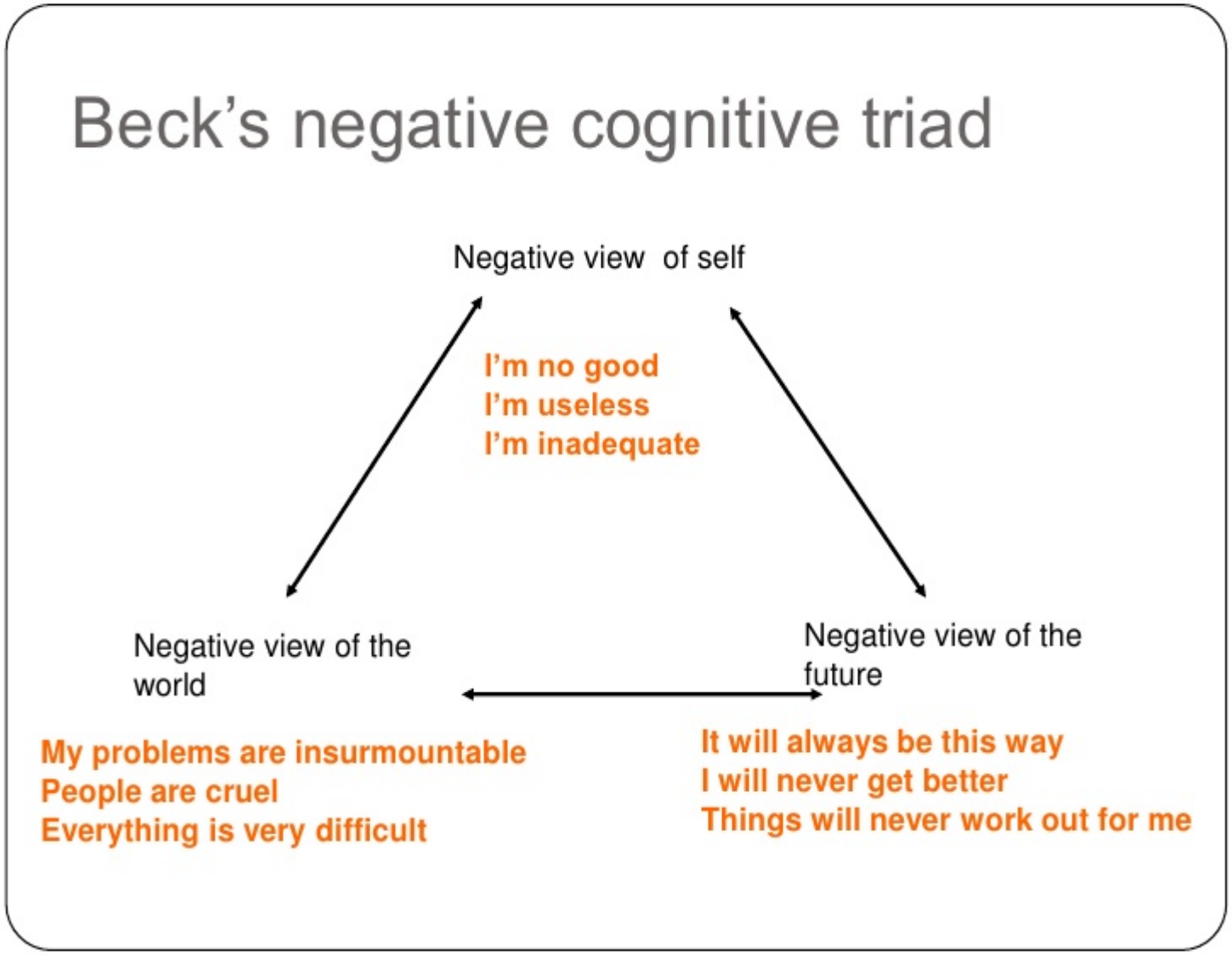
MODEL:

- Persistence
- Realistic optimism
- Bounce Back

(Feeling persistent for a person, then with a person, then supporting them as they persist- treatment beds at Doorway)

VISION:

Trauma may create a view of the self- others, and world as negative, dangerous, untenable, hopeless.



OFFER AN ALTERNATIVE VISION

<u>You are all right in my eyes”</u> (unconditional positive regard)
“I see you as competent, learning, growing, changing”
“I believe you are doing your best”
“I know that you can continue to grow and do better”
“I can see you are trying”
“We all make mistakes”

<u>This Space is Safe</u>
“I want to build a trusting relationship”
“I am trustworthy”
“I will explain what is happening”
“We will both make mistakes and we can talk about them”
“It’s okay to laugh, is it safe to practice joy here”

<u>The future can be better</u>
“Let’s start with a small change today”
“I have hope”
“Tomorrow is a new day, let’s try again”
“I see/ believe in good things for you,
“you are more than your past”

Collaboration & Mutuality

Trauma disrupts healthy attachment and impairs the ~~development of trust.~~

Collaboration seeks expanded support networks, manage perceptions, partner up in change.

“A collaborative therapeutic …relationship is a place to explore problems, have candid conversations, brainstorm potential solutions, and reflect on alternatives” (Bohart et al).

This means voicing different opinions, concerns, curiosity, questions, and ideas about the work, what is helpful or not, working or not.

Collaboration is a partnership that is open, energized, respectful, and purposeful.

Mutuality:
We lead with our personhood

"The ethics of mutuality…are based on real relationships between people, where each has needs and each has limitations and these are discussed openly and honestly. THERE MAY ALSO BE ROLES BUT THESE DO NOT PREVENT EACH PERSON FULFILLING A ROLE FROM PRIMARILY BEING A PERSON. Relationships based on mutuality emphasize equality… and respect for all, rather than dominance and submission…"

-Benjamin, 1988

Collaboration and Mutuality may feel vulnerable.

"Radical" Equality:

No matter what our roles, we are equal an individuals. No person is TOO MUCH, A NO-SHOW, NON-COMPLAINT, or TOO NEEDY. We may recognize an opportunity for growth and acknowledge that we are not able to offer the service they feel they need today.

(The Doorway, housing needs, 24 hour support)

E m p o w e r m e n t

Traumatic experiences breed feelings of passivity and powerlessness, helplessness, shame, guilt. We quite literally lose our voice.

Radical Acceptance: Leading with personhood, acknowledging an individual's ability to make their own best choices, even when we disagree. We can talk it through, and I will not presume to know what is best for you.
Consequences will still be what they are within the roles and systems. We can acknowledge this and still fundamentally respect the person.

"Clearly the way to deal with difficulties that stem from abuse, deprivation, and powerlessness is not to impose further power and control through our systems".

- proctor, G (2004)

Conclusions

1. Co-occurring disorders are defined, in this setting, as the comorbidity of two mental health disorders, including substance use disorder.
2. Co-occurring disorders are prevalent in groups with his exposure to trauma, particularly mood, anxiety, and personality disorders.
3. TIC challenges us to shift our conceptualization, at least in part, from seeing a ‘problem’ as emanating from the person and into the world to seeing a person’s struggles as a manifestation of suffering imposed from the world.
4. The 6 Domains of Resilience can help us to frame our work with clients with co-occurring disorders and trauma in a way that builds the behavioral skills and internal sense of self to develop psychological strength and grit.
5. Leading with personhood and authentic connection over hierarchy and power help clients practice relationships characterized by respect, honestly, warmth, imperfection and humor.
6. This presentation offers an ideal representation that may best be used as a source of robust conversation and thoughtful debate on how some of these tools and principles may be expressed in your organization.

Works Cited

- Common Comorbidities with Substance Use Disorder: NIH/ NIDA. www.drugabuse.gov/publications/research-reports/common-comorbidities
- Strum, Susan (2012). "A Review of the Research on the Relationship Between Substance Abuse and a History of Exposure to Trauma". Ideas and Research you Can Use: VISTAS 2012, Volume 1.
- Proctor, Gillian (2010). "Boundaries and Mutuality in Therapy: Is Mutuality Really Possible or is Therapy Doomed from the Start?" Politics and Psychology, Vol 8, 1, (pp 44-58)