ADDICTIONS AND TRAUMA RECOVERY

Janina Fisher, Ph.D. Instructor and Supervisor, The Trauma Center, Boston, MA Private Practice, Watertown, MA

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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 hypervigilence 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 hypervigilence 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 needed, in conjunction with the alcohol, to increase hypervigilence 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 hypervigilence 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.4

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.

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.

…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.