Treating Trauma in Addiction

Presented by
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&
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Disclosure Statement: Jackie Werboff, MA, LMHC

● Relevant Financial Relationships
  ○ Works as a Primary Therapist and receives a salary from The Augustine Recovery Center
  ○ Owns a mental health therapy private practice and receives payment from clients

● Relevant Nonfinancial Relationships
  ○ Certified Eye Movement Desensitization and Reprocessing (EMDR) Therapist
  ○ Certified NeuroAffective Relational Model (NARM) Therapist
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- **Relevant Financial Relationships**
  - Works as an Assistant Clinical Director and receives a salary from The Augustine Recovery Center

- **Relevant Nonfinancial Relationships**
  - Trained in Eye Movement Desensitization and Reprocessing (EMDR)
  - Certified Master’s Level Addiction Professional (MCAP) and Internationally Certified Alcohol and Drug Counselor (ICADC)
  - Certified Trauma Therapist through Judy Crane’s Spirit to Spirit training
  - Trained in neurofeedback
Overview of Presentation

● The Augustine Recovery Center
● Why treat trauma in addiction?
● Differentiating between shock, developmental and complex trauma
● Identifying intergenerational trauma
● Interventions and treatment for trauma in addiction
● Post-traumatic growth
Learning Objectives

● Understand the importance of addressing trauma in addiction treatment
● Differentiate between shock trauma, developmental trauma and complex trauma
● Identify the significance of intergenerational trauma
● Introduction of different interventions used to address trauma in addiction treatment
● Consider the possibility of post-traumatic growth
The Augustine Recovery Center
The Augustine Recovery Center
The Augustine Recovery Center

- Located on over 8 acres in St. Augustine, FL
  - Northeast corner of the state, just south of Jacksonville and just north of Daytona
- Adult, all male facility with 28 beds, including detox, and a separate location for women with 16 beds opening within the next two weeks
- 90 day minimum residential treatment with an average 120 day stay
- Marriage between a high-accountability 12-Step model and a trauma focused therapeutic approach
  - 12 Step approach includes AA, NA, Al-Anon, ACOA, CODA
- Clients receive an individualized case management and therapy team
- Aftercare and Sober Living options following discharge from treatment
  - Separate male and female sober living properties in downtown St. Augustine
- Family-owned, in recovery
Why Address Trauma in Addiction Treatment?
“Virtually everything that is ‘wrong with you’ began as a compensation, as a survival mechanism in childhood. Therefore, it deserves nothing but respect and compassion.”

Dr. Gabor Maté
Why Address Trauma in Addiction Treatment?

- Addictive behavior is often a manifestation of trauma from earlier life events
- The addictive behavior is the individual’s attempt at finding a solution to their suffering, though ultimately creates more suffering later (Matè, 2010)
- Unaddressed and unresolved trauma can interfere with experiencing safety within treatment, early dropout of treatment and problems maintaining long-term sobriety (Finkelstein et al., 2004)
- Treating both PTSD and Substance Use Disorders- more likely success, more cost-effective and more sensitive to client’s needs (Najavits, 2003)
Objective #1: Differentiating between shock, developmental and complex trauma
Shock Trauma

- Results from an acute, devastating incident
- Leaves individual frozen in fear and time
- Clinically recognized and treated under diagnosis of PTSD

“In single-event shock trauma the defensive-orienting response is overwhelmed, completion of fight-flight is not possible, and individuals stay stuck in an incomplete defensive-orienting response” (p. 118).

- **Therapeutic goal**: Help clients come out of freeze and complete fight-flight responses, typically in a bottom-up approach

  (Heller & Lapierre, 2012)
Developmental Trauma

- Results from ongoing significant and chronic misattunement from caregivers
- Often no single traumatizing event, such as in shock trauma
  - Usually prolonged, familiar, without a distinct beginning and end, and chronic
  - However, early shock trauma also becomes developmental trauma
- Cumulative effects in early life negatively impact brain development, memory, nervous system, and endocrine system

“It is now believed that severe relational trauma can be so powerful as to override every aspect of an individual’s capacity to cope,” (p. 119).

(Heller & Lapierre, 2012)
Developmental Trauma, con’t

● These early experiences of misattunement contribute to future challenges in childhood and into adulthood:
  ○ Fostering a psychobiological process of shame with various attempts to avoid shame and related emotions
  ○ Disrupting physiological and psychological functioning
  ○ An unstable identity and sense of self

● Shock trauma experienced in adulthood often activates earlier developmental trauma issues
  ○ “It is rare that we are able simply to address shock trauma without encountering developmental issues” (p. 274).

● Therapeutic goal: Help clients connect to life force and recover aliveness

(Heller & Lapierre, 2012)
“Early events that may cause long-term traumatic reactions, from conception to 6 months old”

<table>
<thead>
<tr>
<th>Attachment and Developmental Trauma</th>
<th>Shock Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Being carried in the womb of a mother who does not want you</td>
<td>● Attempted abortion</td>
</tr>
<tr>
<td>● Being carried in the womb of a traumatized, dissociated, depressed or</td>
<td>● Mother’s death in childbirth</td>
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<tr>
<td>anxious mother</td>
<td>● Premature birth</td>
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<tr>
<td>● Serious consideration of abortion</td>
<td>● Long, painful delivery</td>
</tr>
<tr>
<td>● Mother abusing substances during pregnancy</td>
<td>● Extended incubation with insufficient physical contact</td>
</tr>
<tr>
<td>● Feeling rejected, blamed or hated by one or both parents</td>
<td>● Early surgeries</td>
</tr>
<tr>
<td></td>
<td>● Significant traumatic events for the mother or other members of the family</td>
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</tbody>
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(Heller & Lapierre, 2012, p. 127)
“Early events that may cause long-term traumatic reactions, from conception to 6 months old”, con’t

<table>
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<tr>
<th>Attachment and Developmental Trauma</th>
<th>Shock Trauma</th>
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<tr>
<td>● One or both parents struggling with connection issues</td>
<td>● Death in the family</td>
</tr>
<tr>
<td>● Attachment attempts with a dissociated, chronically depressed, anxious or angry mother</td>
<td>● Traumatic loss and bereavement</td>
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<tr>
<td>● A mother with psychosis or borderline traits</td>
<td>● Being born into wartime, depression, significant poverty</td>
</tr>
<tr>
<td>● Being made to feel like a burden</td>
<td>● Intergenerational trauma such as being born to Holocaust survivors</td>
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<tr>
<td>● Physical or emotional abuse</td>
<td>● Natural disasters</td>
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<td>● Neglect</td>
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<td>● Adoption</td>
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(Heller & Lapierre, 2012, p. 127)
The ACES Study

- The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study was one of the largest studies to consider the connection between adverse childhood experiences (abuse, neglect and household challenges) and long lasting impacts on health.
- Original ACE study conducted from 1995-1997 with two waves of data collection.
- 17,000+ HMO members receiving physical exams completed surveys about childhood experiences and current health.

(Felitti et al., 1998)
ABUSE
- Physical
- Emotional
- Sexual

NEGLECT
- Physical
- Emotional

HOUSEHOLD DYSFUNCTION
- Mental Illness
- Incarcerated Relative
- Mother treated violently
- Substance Abuse
- Divorce

(CDC, 2020)
The ACEs Study Findings

- ACEs are strongly related to increase of health risk
- ACEs are common across population
- Low socioeconomic status populations are more vulnerable to increased ACEs
- The higher number of ACEs in someone’s first 18 years of life, the higher the risk for negative health outcomes

(Felitti et al., 1998)
Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

(CDC, 2020)
How Common are ACEs?

ACE Score Prevalence for Participants Completing the ACE Module from the 2011-2014 BRFSS

(Merrick, Ford, Ports & Guinn, 2018)
Early Adversity has Lasting Impacts

Adverse Childhood Experiences

- Traumatic Brain Injury
- Fractures
- Burns

Mental Health

- Depression
- Anxiety
- Suicide
- PTSD

Maternal Health

- Unintended pregnancy
- Pregnancy complications
- Fetal death

Infectious Disease

- HIV
- STDs

Chronic Disease

- Cancer
- Diabetes

Risky Behaviors

- Alcohol & Drug Abuse
- Unsafe Sex

Opportunities

- Education
- Occupation
- Income

(CDC, 2020)
Complex Trauma

- Attachment, relational and developmental trauma disrupt healthy self development and identity development (Heller & Lapierre, 2012).
- On June 18 2018, nearly 40 years after the APA officially recognized PTSD as a mental disorder that required clinical treatment, the World Health Organization (WHO) released the ICD-11, including a new diagnosis: 6B41: C-PTSD Complex Post-Traumatic Stress Disorder (Rosenfield et al., 2018).
- “For a person whose symptoms are primarily the result of developmental/relational trauma, a new paradigm is necessary. The sources, causes, and resolution of this kind of trauma are more complex” (Heller & Lapierre, 2012, p. 274).
What is Complex PTSD?

- Difficult to regulate emotions, e.g. self harm, rage
- Difficulties in relationships, e.g. withdrawal, helplessness
- Belief systems affected, e.g. loss of faith, self of self
- Flashbacks, nightmares, (reexperiencing) - PTSD
- Somatic distress, e.g. headaches, pains, nausea
- Hyperarousal, e.g. being “on edge” - PTSD
- Avoidance of reminders, triggers - PTSD
- Altered attention & consciousness, e.g. dissociative amnesia

Complex PTSD involves the core symptoms of PTSD plus additional groups of symptoms. Source: ISTSS Expert Consensus Treatment Guidelines For Complex PTSD In Adults

TraumaAndDissociation

www.dissociative-identity-disorder.net/wiki/Complex_PTSO
Objective #2: Identifying the significance of intergenerational trauma
Intergenerational Trauma Explained

- Trauma transmitted through attachment relationships where the parent has experienced relational trauma
  - Significantly impacts individuals across the lifespan, including predisposition to further trauma (Isobel, Goodyear, Furness & Foster, 2019)
- Psychological effects of trauma are transferred from one generation to another
  - Often began decades prior to the current generation and has impacted the way that individuals understand, cope with, and heal from trauma (Boone, 2020)
Intergenerational Trauma Explained, cont.

● Collective survival experience is **preserved, communicated, and passed down through generations** in the form of **familial, societal or cultural messages and beliefs** (Cherepanov, 2015)

● First studied in 1966 by Canadian psychiatrist Vivian M. Rakoff, MD
  ○ Recorded high rates of psychological distress among children of Holocaust survivors
  ○ In 1988, grandchildren of Holocaust survivors were overrepresented by about 300% in psychiatric care referrals (Gillespie, 2020)

● Trauma is visceral and cellular (Levine, 1997)
  ○ Increased research and evidence supporting the idea that offspring are affected by parental trauma exposures occurring before their birth and transmitted through epigenetics (Yehuda & Lehrner, 2018)
Examples of Intergenerational Trauma

- Being systematically exploited and enduring repeated and continual abuse, racism, and poverty, hate crimes, fear, terror
  - Racial injustice in America
- Enduring war that lasts from years to centuries; Refugee families, military families
- Betrayal, secrets, infidelity, incest, abandonment, divorce, adoption
- Mental, physical, sexual abuse, sexual assault, religious trauma
- Addiction, arrests, suicides, unresolved grief and loss, mental health issues, medical issues
- Generations of less than optimal attachment

“Trauma affects genetic processes, leading to traumatic reactivity being heightened in populations who experience a great deal of trauma” - Gayani DeSilva, MD

(Gillespie, 2020)
Impact of Intergenerational Trauma

- Negative effects can include a range of psychiatric symptoms as well as greater vulnerability to stress (Sangalang & Vang, 2017)
- Invisible backpack concept- Imagine a backpack being handed down from one generation to the next, carrying around the weight of generational trauma
  - “Left unhealed, the wounds of traumatic events cause pain and produce ongoing, devastating generational family marks” (Sells, 2018)
  - “The trauma rides along our genes like an anxious passenger. Wanting truths to be told. Wrongs to be righted. Justice to be served.” (Grace, 2020)
Incorporating Intergenerational Trauma into Care

- Culture-informed treatment is necessary
- Family Systems therapy
  - Allow family members to share their own trauma histories
  - Uncover unhealthy communication patterns and help clients and families form new ways of healthy communication
- Give generational trauma a voice through naming it and allowing the impact to be explored
- Help clients differentiate and to make choices about how they want to incorporate the family’s history into their present and future
  - Can be a powerful vehicle to change unwanted behaviors, break cycles and transform

(Sells, 2018)
Helping Clients Identify Intergenerational Trauma

- Inclusion of intergenerational messages and themes from maternal and paternal sides of family, dating as far back as possible
  - Weave into insight assignments (Genograms, family trees, trauma egg, narrative therapy)
    - Messages around finances, poverty
    - History of addiction and other “-isms”
    - Immigration, cultural and ethnic beliefs, historical trauma, military background, religious beliefs
    - Male/female roles
    - Infidelity, secrets

- Suggest clients ask family members about the generational history
  - Often the lack of communication about the past or “unspoken” truths have contributed to the cycle
  - May only be familiar with one side of the family
  - A lack of any available information about one’s history can be trauma within itself
Objective #3: Interventions and treatment for trauma in addiction
Interventions and treatment for trauma in addiction

Neurofeedback

Eye Movement Desensitization and Reprocessing (EMDR)

NeuroAffective Relational Model (NARM)

Seeking Safety

Shame Resilience

Therapy Assignments, Experiential Modalities and Creative Expression
Neurofeedback

- Electrodes are applied to client’s scalp to listen in on brainwave activity, the signals are processed by a computer program and information is extracted about certain key brainwaves
  - Some brain waves are promoted and some are diminished based on individual activity
- The information is presented to the client in the form of a video game that client is playing
- Eventually, client’s brainwave activity is shaped toward more desirable and regulated performance
- Specific locations targeted on the scalp vary based on conditions and issues that need addressing

(Eeg Info, 2020)
Neurofeedback, con’t

- Goals of Neurofeedback:
  - Physiological self-regulation, psychological resolution, reduced symptoms, improved function, increased well-being and quality of life (Othmer, 2019).
  - Symptom improvement can include physical instabilities (asthma, allergies, snoring, sleep apnea, etc.) ADHD, autism, bipolar, depression, sleep, balance, trauma responses, reading, writing, memory, impulse control and a wide variety of other issues

- Example: High beta waves
  - High beta waves common in anxious brains, brains that have experienced trauma or ADD
  - Symptom of high beta waves include difficulty falling asleep, poor concentration, restlessness, hypervigilance, frequent waking, lack of presence in conversation, restless legs, body tenseness, agitation, tremors etc.- scanning the environment for danger
  - Neurofeedback will help the brain lower beta waves on its own. As Neurofeedback sessions increase, the brain will be able to hold the changes outside of training sessions
From stick figures to clearly defined human beings. After four months of neurofeedback, a ten year old’s drawings show the equivalent of six years of mental development.”

Van der Kolk, 2015
Treating Trauma with Neurofeedback

- Excessive activity in the right temporal lobe (fear center of the brain) combined with too much frontal slow-wave activity = hyper-aroused emotional brains dominating the mental life
  - Calming the fear center decreases trauma-based problems and improves executive functioning, leading to decrease in PTSD scores, improved mental clarity and an increase in ability to regulate one’s self (Van der Kolk, 2015)
- Provides the body-mind the visceral experience of calmness, which has been blocked off, and reinforces this state (Othmer and Othmer, 2009)
- Training the right side of the brain for emotional regulation (anxiety, depression, trauma, attachment, SI, self-harm, etc.)

*How Neurofeedback Can Change the Way We Approach Trauma Treatment* (PRAXIS, 2019).
Neurofeedback, con’t

- Alpha-Theta training added after improved physiological self-regulation is achieved with the open-eye game training (10-20 sessions)
  - Addresses unresolved traumatic experiences, fears and habits that continue to trigger uncomfortable feelings and behaviors, and habits formed during addiction
  - Holds client in a deeply relaxed state in which traumatic memories can surface and be processed, with or without conscious awareness (use of blankets, eye masks, reduced sensory input to relax cortex into a witness state while subcortical processing occurs)
  - Two layers of auditory feedback with brain shifting back and forth between alpha (relaxed) and theta (edge of sleep) states, bringing up unprocessed memories and allowing them to be stored as memories stripped of emotional charge (Othmer, 2019).
Eye Movement Desensitization and Reprocessing (EMDR)

- EMDR helps clients access, process and heal symptoms and distress from disturbing life events
- EMDR utilizes bilateral stimulation/dual attention stimuli while the client is processing emotionally distressing material
  - Stimulation can be visual (clients’ eyes tracking therapist’s fingers or tracking lights on a light bar), auditory (client wears headphones and hears simultaneous tones in either ear) and/or tactile (client holds stimulation device that delivers simultaneous vibrations to either hand). Variations in stimulation can occur independently or integrated together
- Successful EMDR treatment results include relief from emotional distress, reprocessing of negative beliefs and decreased psychological arousal

(Shapiro, 2001)
Eye Movement Desensitization and Reprocessing (EMDR)
Eye Movement Desensitization and Reprocessing (EMDR)

- EMDR uses an 8-phase treatment approach (Shapiro, 2001)
  - **Phase 1**: History taking, assessing client’s readiness, client and therapist identify possible EMDR targets (past or present distressing events)
  - **Phase 2**: Establishing resources (grounding techniques, Peaceful Place, Safe Container, etc.) and assessing client’s capacity to handle emotional distress
  - **Phase 3-6**: A target memory is identified and processed using bilateral stimulation/dual attention stimuli and treatment protocol. The client identifies a distressing visual image associated with the target, a negative cognition, a desired positive cognition the client would like to have about the self, notes emotions and body sensations and rates intensity of emotional distress throughout the EMDR session.
  - **Phase 7**: Emotional grounding using previously established resources, client is encouraged to keep a journal to document any material that may arise
  - **Phase 8**: Occurs at the client’s next session, examining any progress or setbacks since the last EMDR session
NeuroAffective Relational Model (NARM)

- “Connection: Our Deepest Desire & Greatest Fear”
- A developmentally-oriented and neuroscientifically-informed
- Mindfulness-based, phenomenological, resource-oriented and non-regressive to address interrupted identity development
- Focus on restoring connection with self and others
- Address issues of identity and the capacity for connection and regulation
- Works with unconscious attachment patterns that stem from relational, developmental and attachment trauma and adverse childhood experiences

(Heller & Lapierre, 2012)
NeuroAffective Relational Model (NARM), con’t

● Core Principles:
  ○ **Top-down and bottom-up**: integrating a nervous system based and a relational orientation; top-down- cognitions and emotions, bottom-up- the body
  ○ **Containment**: developmentally-informed clinical interventions with somatic mindfulness and an orientation to resources for nervous system self-regulation
  ○ **Re-Regulation**: links psychological issues and the body by accessing self-regulatory capacities and by supporting nervous system re-regulation
  ○ **Disidentification**: mindful inquiry used to explore identifications and counter-identifications that clients take to be their identity

● Organizing Principles:
  ○ Supporting connection and organization
  ○ Exploring identity
  ○ Working in present time
  ○ Regulating the nervous system  
  
  (Heller & Lapierre, 2012)
## NARM® Clinical Protocol

<table>
<thead>
<tr>
<th>Attunement</th>
<th>Intention</th>
<th>Help clarify client’s struggle and what they want</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Client Intervention</td>
<td>Clarify the therapeutic contract - Pillar #1</td>
</tr>
<tr>
<td></td>
<td>Self-Inquiry</td>
<td>Notice how it feels to be with the client</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Acceptance</th>
<th>Intention</th>
<th>Hold space for client’s complexity</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Client Intervention</td>
<td>Ask exploratory questions - Pillar #2</td>
</tr>
<tr>
<td></td>
<td>Self-Inquiry</td>
<td>Notice the impulse to fix, oversimplify, and rush to premature conclusions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reflection &amp; Exploration</th>
<th>Intention</th>
<th>Understand how client organizes their inner experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Client Intervention</td>
<td>Clarify the core dilemma</td>
</tr>
<tr>
<td></td>
<td>Self-Inquiry</td>
<td>Lightly hold working hypothesis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mindful Interventions</th>
<th>Intention</th>
<th>Hold possibility for new way of client relating to self and world</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Client Intervention</td>
<td>Support increased sense of agency - Pillar #3</td>
</tr>
<tr>
<td></td>
<td>Self-Inquiry</td>
<td>Notice tendency to be goal-driven</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Integration</th>
<th>Intention</th>
<th>Support client’s increase in psychobiological capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Client Intervention</td>
<td>Reflect psychobiological shifts - Pillar #4</td>
</tr>
<tr>
<td></td>
<td>Self-Inquiry</td>
<td>Notice capacity to be present with and impacted by client</td>
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</tbody>
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**NARM® Emotional Completion Model**

- **Step 1**: Identify Primary Emotion
- **Step 2**: Reflect on Emotion’s Intention
- **Step 3**: Support new relationship to unresolved emotional conflicts
NeuroAffective Relational Model (NARM), con’t

- Organizing Developmental Themes and Associated Resources
  - essential for capacity for self-regulation
  - affect ability to be present to self and others

“Connection. We feel that we belong in the world. We are in touch with our body and our emotions and capable of consistent connection with others.

Attunement. Our ability to know what we need and to recognize, reach out for, and take in the abundance that life offers.

Trust. We have an inherent trust in ourselves and others. We feel safe enough to allow a healthy interdependence with others.

Autonomy. We are able to say no and set limits with others. We speak our mind without guilt or fear.

Love-Sexuality. Our heart is open and we are able to integrate a loving relationship with a vital sexuality.”

(NARM Training Institute, 2019)
NARM: Working with Complex Trauma & Addiction

Mike Giresi CAC, CTP, ICADC, NMP, Director of Clinical Development at Family First Adolescent Services and NARM Training Assistant

Brad Kammer, LMFT, LPCC, SEP, NMT, NARM Training Director

(NARM Training Institute, 2018)
<table>
<thead>
<tr>
<th>CORE NEED</th>
<th>ASSOCIATED CORE CAPACITIES ESSENTIAL TO WELL-BEING</th>
</tr>
</thead>
</table>
| CONNECTION | Capacity to be in touch with our body and our emotions  
             Capacity to be connection with others               |
| ATTUNEMENT | Capacity to attune to our needs and emotions        
             Capacity to recognize, reach out for, and take in physical and emotional nourishment |
| TRUST      | Capacity for healthy dependence and interdependence  |
| AUTONOMY   | Capacity to set appropriate boundaries               
             Capacity to say no and set limits                 
             Capacity to speak our minds without guilt or fear |
| LOVE~SEXUALITY | Capacity to live with an open heart                    
             Capacity to integrate loving relationships with a vital sexuality |

NARM’s five core needs and their associated core capacities.

(Heller & Lapierre, 2012)
<table>
<thead>
<tr>
<th>CORE NEED</th>
<th>SURVIVAL ADAPTATION</th>
<th>STRATEGY USED TO PROTECT THE ATTACHMENT RELATIONSHIP</th>
</tr>
</thead>
</table>
| Connection | Foreclosing connection  
Disconnect from body and social engagement | Children give up their very sense of existence, disconnect, and attempt to become invisible                      |
| Attunement | Foreclosing the awareness and expression of personal needs | Children give up their own needs in order to focus on the needs of others, particularly the needs of the parents |
| Trust      | Foreclosing trust and healthy interdependence                                      | Children give up their authenticity in order to be who the parents want them to be: best friend, sport star, confidante, etc. |
| Autonomy   | Foreclosing authentic expression, responding with what they think is expected of them | Children give up direct expressions of independence in order not to feel abandoned or crushed                     |
| Love–Sexuality | Foreclosing love and heart connection  
Foreclosing sexuality  
Foreclosing integration of love with sexuality | Children try to avoid rejection by perfecting themselves, hoping that they can win love through looks or performance |
NeuroAffective Relational Model (NARM), con’t

Working with the life force:

“The spontaneous movement in all of us is toward connection, health, and aliveness. No matter how withdrawn and isolated we have become or how serious the trauma we have experienced, on the deepest level, just as a plant spontaneously moves toward sunlight, there is in each of us an impulsive moving toward connection and healing. This organismic impulse is the fuel of the NARM approach”

(Heller & Lapierre, 2012, p. 28).
Seeking Safety

- First modality with published outcome results to address PTSD and Substance Use Disorders (SUD)

- Treatment Format:
  - 25 topics total, can be presented in any order
  - Treatment can be longer or shorter than 25 sessions
  - Designed to be integrated with other treatments
  - Can be conducted in a wide variety of formats
  - Can be applied to a wide population
  - Relevant for clients that do not meet diagnostic criteria for PTSD or SUD
  - Highly structured

(Najavits, 2003)
Seeking Safety, con’t

- Based on 5 central ideas:
  - 1) safety as the priority with “safety” refers to discontinuing substance use and self-harm behaviors; reducing suicidality, exposure to HIV risk, dangerous relationships and gaining control over extreme symptoms
  - 2) integrated treatment of PTSD and substance abuse with attention to both disorders at the same time in the present (each topic applies to trauma and substance abuse)
  - 3) a focus on ideals, specifically restoring positive ideals that have been lost
  - 4) four content areas: cognitive, behavioral, interpersonal and case management
  - 5) attention to therapist process including therapeutic alliance, compassion for clients’ experience, using coping skills in personal life, giving clients control when possible, healthy modeling, seeking feedback from clients

(Najavits, 2003)
Seeking Safety, con’t

- 25 Treatment Topics
  - Introduction to treatment/Case Management
  - Safety
  - PTSD: Taking Back Your Power
  - Detaching from Emotional Pain (Grounding)
  - When Substances Control You
  - Asking for Help
  - Taking Good Care of Yourself
  - Compassion
  - Red and Green Flags
  - Honesty
  - Recovery Thinking
  - Integrating the Split Self

(Najavits, 2003)
Seeking Safety, con’t

- 25 Treatment Topics, con’t
  - Commitment
  - Creating Meaning
  - Community Resources
  - Setting Boundaries in Relationships
  - Discovery
  - Getting Others to Support Your Recovery
  - Coping with Triggers
  - Respecting Your Time
  - Healthy Relationships
  - Self-Nurturing
  - Healing from Anger
  - The Life Choices Game
  - Termination

(Najavits, 2003)
Shame Resilience

- *Connections*, a 12-Session Psychoeducational Shame-Resilience Curriculum

- Developed by Brené Brown to help professionals and clients recognize and understand shame and develop shame resilience

(Brown, 2009)
Shame Resilience, con’t

“I would say that shame and fear are the greatest obstacles to authenticity, love and belonging, and a resilient spirit. Shame tells us that we are unworthy, unlovable, and, worst of all, incapable of change. Shame tells us that our imperfections make us inadequate and our vulnerabilities are weaknesses. It sends two primary messages: ‘Who do you think you are?’ and ‘You’ll never be good enough’... As we work with clients on these issues, our greatest charge is helping them understand these two points: 1) Our imperfections do not make us inadequate; they are what connect us to each other and to our humanity. 2) Our vulnerabilities are not weaknesses; they are powerful reminders to keep our hearts and minds open to the reality that we’re all in this together.”

(Brown, 2009, p. 4)
The Four Attributes of Empathy

- Perspective-taking
- Staying out of judgment
- Recognizing emotions
- Communicating our understanding of emotions

Connections: A 12-Session Psychoeducational Shame-Resilience Curriculum

The Twelve Categories of Shame

- Appearance and body image
- Money and work
- Motherhood/fatherhood
- Family
- Parenting
- Mental and physical health, including addiction
- Sex
- Aging
- Religion
- Speaking out
- Surviving trauma
- Being stereotyped and labeled
Shame Resilience, con’t

● Session 1: Introduction
  ○ Worksheet- Defining shame

● Session 2: Overview of Curriculum and Defining Shame
  ○ Handout- Shame-Resilience Model, Worksheets- Feeling Shame, Understanding Shame

● Session 3: Big Webs and Small Boxes
  ○ Handouts- Shame Web and Shame Box

● Session 4: Defining Resilience- Practicing Empathy
  ○ Handout- Influences on How We See the World, Worksheet- Understanding Empathy

● Session 5: Practicing Empathy
  ○ Handout- Connection Network, Worksheet- Experiencing Shame

● Session 6: Recognizing Shame
  ○ Worksheet- Recognizing Shame (Brown, 2009)
Shame Resilience, con’t

● Session 7: Exploring Triggers and Vulnerabilities
  ○ Handout- Shame Categories, Worksheet- Shame and Identity

● Session 8: Understanding Our Shame Screens
  ○ Worksheet- Strategies of Disconnection

● Session 9: Practicing Critical Awareness
  ○ Worksheets- The Big Picture, The Reality Check

● Session 10: Reaching Out
  ○ Handout- Helping Others Understand Your Feelings, Worksheet- Sharing Feelings

● Session 11: Speaking Shame
  ○ Worksheet- Requesting Support

● Session 12: Authenticity and Shame Resilience
  ○ Handout- Authenticity

(Brown, 2009)
Therapy Assignments & Experiential Modalities

- Trauma Egg (Murray, 2019), Financial Egg, Hero Egg, Angel Egg, Sex Addiction Egg
- Body Map (Devine, 2008)
- Narrative Modalities
  - No-mail letters, personifying addiction, Love Letter, When Grief Came Knocking, If These Walls Could Talk, My Heart Broke When..
- Inner Child
- Inner Critic
- Experiential Anger Expression
- Psychodrama, Family Sculpting
  - Healing experiences in action
The trauma egg was developed as a tool for treating emotional trauma by Marilyn Murray, an internationally-recognized authority on trauma, abuse, deprivation, and its consequences.
A Body Map created by a client at The Augustine Recovery Center in 2020
Objective #4: Post-Traumatic Growth
Post-Traumatic Growth

- Supporting disidentification and possibilities for transformation
- Measured by experience of internal freedom
- Expanding psychobiological capacity (Heller & Lapierre, 2012)

“Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom.”

-Viktor Frankl
What is Post-Traumatic Growth?

with

Sonja Lyubomirsky, PhD

(NICABM, 2017)
Brutally Honest Optimism
Optimism reduces our sense of helplessness when things feel out of control. It also allows us to take constructive action. However, this is not the Pollyanna, unicorns and rainbows, 'everything’s going to be okay' brand of optimism— it is tempered by the discipline to confront the most brutal facts of our current reality.

Perception of Control Over Events
What makes an experience traumatic is that we were not able to control the circumstances that led to us being harmed in some way. Recovery is about regaining control through primary control (taking action to change a situation) or secondary control (changing our orientation to a situation).

4 Factors Leading to Post-Traumatic Growth

Coping Style
What is your coping style? Do you immediately start problem-solving (active coping) or do you escape into a fantasy world (avoidance coping)? Both approaches can be helpful, but in the long term, avoidance turns into denial, which prevents you from ever truly living in the present because you are too busy stuffing down your past. The best predictor of post-traumatic growth is 'acceptance and positive reinterpretation' - a coping style characterized by optimism and humor.

Strong Sense of Self
Having a strong sense of self depends on having a purpose in life, high self-esteem, and being able to create a coherent narrative. Without being able to make sense of our story, we cannot integrate it, learn from it, or get a distance from it. A coherent narrative prevents us from unconsciously repeating the lack of connection we experienced with our parents in our relationships with our own children.

5 Domains of Post-Traumatic Growth

Personal Strength
- Stronger for the experience
- Better able to handle blows
- More wisdom and maturity

Closer Relationships
- Strengthened social ties - can rely on people
- Help craft trauma narratives that contribute to meaning
- Sense of belonging
- Unity

Greater Appreciation for Life
- Greater gratitude, hope, kindness, leadership, love, spirituality, and teamwork

New Possibilities
- Reprioritize values and time commitments
- Accomplish goals that would have been delayed
- More understanding of friends and family

Spiritual Development
- Rejected spiritual beliefs to encompass trauma, or
- Revise spiritual beliefs altogether

(Echo, 2018)
TRAUMA RESILIENCE

NEW POSSIBILITIES
See things from another angle, knock down barriers that have held you back, tap into a new purpose for your life.

INCREASED STRENGTH
Build resilience in the face of challenge. Each problem you tackle, learn from and overcome, leaves you stronger and more confident.

MORE MEANINGFUL RELATIONSHIPS
Dealing with a challenge can create more empathy in your heart and an overall desire to love and help others. You also recognize who your “real” friends are and have a desire to form appropriate boundaries to support your growth.

GREATER APPRECIATION
It's easy to get wrapped up in life and forget about expressing gratitude. When a trial knocks you down, it has a way of making life that much more valuable.

SPIRITUAL DEVELOPMENT
A deep faith in God or the divine has been shown to increase the probability of survival. When you experience something difficult, often all you are left with is faith.

THE 5 GIFTS OF CONQUERING ADVERSITY

(Roser, 2015)


References, con’t


References, con’t


