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On Co-Occurring Mental Health and Substance Abuse Disorders

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THE TREATMENT OF TRAUMA AND CO-OCCURRING DISORDERS

By Denise Tordella, M.A., LPC

Individuals with co-occurring mental health & substance abuse disorders (COD) are more likely to have a history of physical & psychological trauma. Mental health & substance abuse counselors often view their clients' physical, emotional, and sexual abuse histories as secondary rather than as root causes for co-occurring disorders. However, research demonstrates that untreated trauma among individuals with co-occurring disorders often increases the need for more intense and frequent psychological and support services.

A co-occurring diagnosis of Post-Traumatic Stress Disorder (PTSD) has been associated with poorer substance abuse treatment outcomes. Individuals with PTSD relapse more quickly consume more substances when they drink/drug, experience more days of severe drug consumption, and suffer greater negative consequences as related to their addiction than do their non-PTSD counterparts.

Unfortunately, traditional treatment has not attended to these issues. Most individuals do not receive assessment or treatment for their trauma experiences. For example, though well intended, the dated maxim of "Don't work on the PTSD until you've been clean for a year" is counter to the clinical evidence that recommends an early and increased focus on diagnosing and treating trauma disorders.

The screening and effective diagnosis of trauma, often a central reason for the client's presenting symptoms, may greatly increase the effectiveness of treatment. However, without a proper assessment, counselors may incorrectly attribute PTSD symptoms to other current psychiatric disorders. Therefore, it is important to clinically know the ways past trauma experiences are expressed in a client's current behavior and affective states. By adopting this diagnostic/treatment approach, the subsequent treatment outcome should be more effective in reducing a client's relapse potential as related to their co-occurring disorder.

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POST-TRAUMATIC STRESS AND THE HISPANIC CLIENT

By Pedro Aybar, LCADC, LSATP

The Hispanic population in the United States is nearly 37 million and rapidly becoming our nation's largest minority group (Census Bureau, 2003). And the Hispanic culture is changing the American landscape in a variety of economic, social, and political ways. This immigration helps create a new social community that not only contributes to our society but is also in need of various kinds of health and human services.

In the Washington Metropolitan Area, the Hispanic presence is nationally diverse, though there are large concentrations of Hispanics from Central America. They are the newest Hispanic subgroup in the United States and many have fled their native homelands in fear of political terror and atrocities. And although the specific social, historical, and political contexts differ in El Salvador, Guatemala, and Nicaragua, these conflicts led to a significant emigration of citizens.

The circumstances that caused various Hispanic groups to migrate greatly influence their experience in the United States. For example, Cubans fled a Communist state

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government and were welcomed with support through refugee or entrant status, work permits and citizenship.

Puerto Ricans are by definition U.S. citizens and as a result, have ready access to government-sponsored support services. In contrast, many Central American immigrants are not recognized as political refugees, despite the fact that they fled war-related trauma. For many of these immigrants, their past put them at high-risk for post-traumatic stress disorders (PTSD) and makes their adjustment to this new home all the more difficult.

Many Hispanic who arrive without proper documentation have problems obtaining employment and live in chronic fear of deportation. Many come as unskilled laborers or displaced agricultural workers who lack the social and economic resources to ease their adjustment and the primary education necessary to begin on the road to recovery. Conversely, Hispanics are often referred to as a family-oriented culture that benefits from the social support and community connections that promote survival and adjustment. However, often their overall social-economic class does not easily recommend a psychotherapeutic approach to emotional and/or substance abuse problems.

Central American refugees have a history of experiencing systematic violations of human rights, and are at high-risk for mental disorders such as PTSD and depression. The major drugs of choice are alcohol, marijuana and in fewer cases cocaine. As a group, Hispanics are an underserved population for mental health and addictions services for cultural, linguistic and political reasons. For example, there are roughly 29:100,000 Hispanic mental health professionals as compared to 173:100,000 non-Hispanic whites.

Some local jurisdictions, such as Fairfax County, Virginia have created programs that are language accessible and culturally competent in providing mental health and substance abuse services. There is a residential “Nuevo Dia” program as well as co-occurring programs for Hispanic inmates at the Fairfax Adult Detention Center. Also, there is the Falls Church Adult Outpatient site, which is staffed by bilingual professionals.

Hispanics that suffer from PTSD and depression feel as though they have few options on how to cope with all these challenges. One avenue of coping is through alcohol consumption as a kind of stress reliever that unfortunately leads to other more complex maladaptive behaviors and problems, such as domestic violence, drinking in public, street fights, and driving while intoxicated.

The establishment of a “working alliance” is a prerequisite to any counseling relationship, and the development of such an alliance takes time. This demands that the counselor frequently assess the client’s sense of safety and psychological stability. Overall, the creation and development of a safe and stable working alliance must occur before any evaluation of the traumatic experience. This is especially true for immigrants who are trauma survivors and are still involved in the initial acculturation process.

The length of time and the actual reasons for disclosing the traumatic experience can vary on a case-by-case basis. The reasons behind the disclosures may generate feelings of guilt & shame, fear of stigmatization & other social repercussions, and a generalized distrust of others. This is an especially important concern because the previous traumatic environment may have fostered mistrust as a survival mechanism.

Initially, individual counseling can be successful in forging an alliance and developing a safe psychological environment. Individual counseling can be very useful in facilitating disclosure of the trauma. Individual consultation may allow the client the opportunity for an in-depth exploration of their particular issues and allow the therapist to tailor the work to client’s particular needs. As treatment progresses, group counseling can also be useful in working with Hispanics who have successfully advanced themselves in the therapeutic relationship. In this way, group counseling and group sharing allows clients to have contact with other people suffering from a similar situational experiences. These small group experiences help break the cycle of isolation and feeling of aloneness.

It is useful that counselors emphasize the social resources and coping skills that immigrants employ in dealing with their acculturation. Similarly, the client’s level of functioning should be regularly assessed to determine how well they are doing in all other areas of his or her life. There are several self-reporting measures to assess acculturation and racial identity that can be used for this population. And since this identity process and social status is of critical importance in Spanish societies, these issues can be substantive and complex. This is especially true for persons who continue to identify themselves very strongly with their country of origin.

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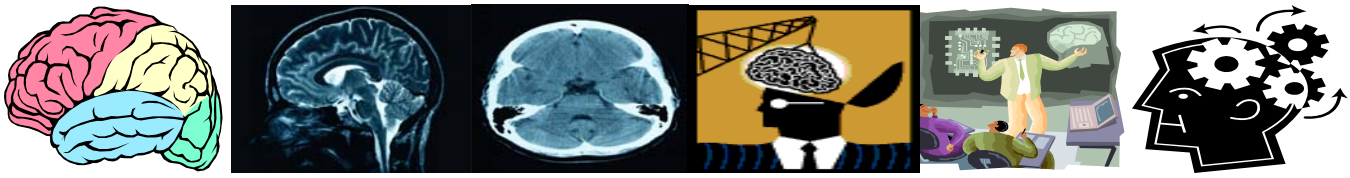

ALTERATIONS IN BRAIN STRUCTURE & FUNCTION AND PTSD

By Penny Cameron, A.P.R.N.C.- B.C.

Post-Traumatic Stress Disorder (PTSD) is categorized as an anxiety disorder that is distinguished by neuro-physiological symptoms. These symptoms are the result of exposure to an extraordinarily stressful, life-event involving near death experiences or serious injury. The response to these events involves intense fear, helplessness and/or horror (DSM IV-R). This article will examine current research that demonstrates a wide-range of neurological changes that occur in association with the symptoms of PTSD.

PTSD is diagnosed by the presence of significant distress in response to environmental cues that trigger the re-experiencing of the trauma. The symptom most commonly associated with PTSD is "fear". Fear is a normal emotion necessary for survival and self-preservation; however, what differentiates normal-fear from those emotions experienced in PTSD is their degree of 'excessiveness' that are unwarranted and results in 'dysfunction'.

It is currently believed that a person who is exposed to trauma and subsequently develops PTSD has also experienced structural and functional brain alterations. That is, the origin of the stress syndrome represents actual changes in the brain. Research advances in molecular genetics and functional neuroimaging support this belief and these findings are changing our conceptualization of the nature of psychiatric disorders. For example, it was once thought that a single, or a few genes, were responsible for major psychiatric disorders. Research in molecular genetics now indicates that various genes regulate the neuro-physiology of specific brain circuits that are associated with psychiatric disorders. (Stahl, 2003)

From this perspective, psychiatric illnesses appear to be caused by the inheritance of genes that represent risk factors for illness manifestation. Those risk factors may lead to the malfunctioning of neuronal circuits that remain 'asymptomatic', unless provoked by environmental stressors. In the case of PTSD, a significant trauma becomes the environmental stressor that evokes symptom expression that formulates the diagnosis of PTSD.

Abnormalities in brain circuits can be increasingly detected with functional neuroimaging techniques. Although behavioral symptoms can result from abnormalities in brain circuits, they may not always appear since compensation can occur in otherwise healthy individuals. Findings from neuroimaging studies complement our understanding of the wide-ranging neurobiological changes that occur in trauma survivors who develop PTSD (Hull, 2002).

The areas of the brain primarily responsible for the symptoms of anxiety are the *amygdala, thalamus, hippocampus* and *medial & orbital prefrontal cortex*. The *amygdala* is the "panic button" of the brain. The *amygdala* innervates other structures of the brain that express the emotion fear with endocrine and motor changes. The malfunction of the neuroanatomical circuit that mediates fear underlies the symptom constellation that determines the diagnosis of PTSD.

The fear-response has many components that include: motor (fight or flight or freezing), endocrine (cortisol response), respiratory (increased respiratory rate and hyperventilation), and cardiovascular (increased heart rate and blood pressure). Magnetic Resonance Imaging (MRI) has demonstrated that the magnitude of the *amygdala's* automatic responses can be distinguished from patients without PTSD. (Rauch et al, 1996).

Some inputs to the *amygdala* come directly from the *sensory thalamus* and are rapid, resulting in fear reactions that are reflexive and without thought. Other inputs are detoured to the *prefrontal cortex, sensory cortex or hippocampus* where they are analyzed before hitting the "panic button". (Stahl, 2002)

The following details associated anxiety symptoms with specific brain areas:

- Pre-frontal cortex: *Panic, phobia, anxious misery, apprehension, obsessions*
- Amygdala: *Panic, phobia, re-experiencing*
- Thalamus: *anxious misery, apprehension, obsessions*
- Hippocampus: *re-experiencing*
- Brainstem: *autonomic responses*
- Striatum: *anxious misery, apprehension, obsessions*

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Functional MRI studies have shown localized changes or malfunctions in neurocircuitry, which include a simultaneous activation of the *amygdala* after symptom provocation and decreased activity of the *Broca's area* (left frontal lobe). Decreased activity of the *Broca's area* when traumatic related memories are provoked can explain why patients with PTSD experience intense emotions without being able to label and understand them. (Hull, 2002)

The most replicated structural finding in patients with PTSD is *hippocampal* volume reduction. Neuronal loss in the hippocampus may limit the proper evaluation and categorization of experience or memory processing. (Hull, 2002)

Positive Emission Tomography (PET) studies have shown dysfunction of *medial & orbital prefrontal cortex* during PTSD symptom provocation, in response to traumatic cues. (Friedman, 2005) This is the area of the brain that analyzes (inhibitory control) whether the "panic button" in the *amygdala* is activated. If there is dysfunction, this may account for the initiation of fear, anxiety, apprehension and the obsessions often seen in PTSD.

Current research into the impact of gene function, brain function and structural changes related to PTSD is in its infancy. However, the concept of malfunctioning neuronal circuits and structural brain change supports a biological basis of symptom presentation. Also the outcome of this model allows clinicians to select treatment strategies based on the specific individual symptom profiles.

The clinical implications are that by identifying the brain circuits, key neurotransmitters will be identified, and thereby aide in the selection of appropriate pharmacotherapy for specific symptom remission. These findings can also be applied to the development of psychotherapy strategies and behavioral management techniques that can modulate the internal and external cues that precipitate and modulate PTSD.

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Counselors are encouraged to use a "strength-based" perspective when treating trauma survivors with co-occurring disorders. A strength-based perspective offers a positive view and a collaborative way of working with clients. A strength-based (asset) model shifts the focus from targeting problems to identifying the coping strategies the client is presently using as their means of adapting to the consequences of their illnesses. As such, this "asset model" is supportive in nature and helps the clients understand their strengths and their skills that will aid them in the recovery process.

Some of the advantages of a strength-based perspective are an early, increased and positive therapeutic alliance that highlights internal resources rather than identifying barriers. This clinical strategy reduces the client's shame and guilt that is often associated with discussing their life experiences. Also, past & present symptoms are reframed as coping strategies. This approach emphasizes resiliency, creativity, intelligence, strength and responsibility and enables the counselor to collaborate with the client to foster psychological growth and personal development**.**

An integrated recovery approach to trauma and other CODs often includes an educational component. With trauma clients, one goal of psycho-education is to help them reframe their current symptoms as attempts to cope with past experiences. In this way, the client learns to appreciate the ways and means by which their lifestyle has become determined by certain repetitive behaviors.

Responsible trauma treatment does not rush headlong into uncovering trauma memories and it is conceptualized that there are three stages of trauma treatment: safety, mourning and reconnection. Trauma treatment begins with a safety and stabilization phase that builds coping skills and an understanding of emotional responses. Therefore, the client begins by gaining access to their personal resources, strengths, and positive emotions prior to working with the trauma. Initially, the focus is on helping clients manage their anxiety and depression as well as learn to "self-soothe". That is, the goal is to help client develop more adaptive resources.

It is important to obtain a history of a client's survival skills and their ability to dissociate. This stage will also include a discussion and agreement as to the ongoing availability of the counselor. The agreement is a balance that fosters self-reliance and reduces the counselor's role as an external source for self-regulation. However, the client must have internalized sufficient self-nurturing techniques to maintain safety and control over mental health and substance abuse relapse symptoms. Whereas PTSD and substance abuse are by nature disorders of loss of control, the goal of trauma treatment is safety and empowerment. As such, every clinical session should address the interrelationship among trauma, mental health and substance abuse disorders.

It is also important to be aware of the ethical considerations and guidelines in trauma treatment. They include informed consent, developing & maintaining boundaries and counselor self-care. In giving consent to treatment, clients must appreciate the fact that psychologically working on trauma issues may exacerbate symptoms prior to any resolution. Conversely, the counselor should become vigilant regarding their personal mental health concerns and may need to seek supervision, consultation and professional support. In most cases, consultation and supervision by a trauma specialist is critical to the process of a human understanding of the trauma material and a facilitating therapeutic emotional response. In this way, trauma-related work can be emotionally difficult and requires clinical support.

Overall, providing integrated treatment for trauma survivors is critical for the successful treatment of co-occurring disorders. Substance abuse and mental health therapists should have clinical training to assess for various trauma histories and disorders and more fully understand the differential diagnosis and co-morbidity of addictions and PTSD. In this way, the counselor's self-efficacy and professional competency will expand proportionately, and gain more professional satisfaction in working with dually diagnosed clients who are often labeled as difficult to treat.

For additional information on Trauma
and related resources go to:
www.ojp.usdoj.gov
Under Crime Victims, see Victims of Crime.
Then go to "Help for Victims" for a listing
of contact & resources.

This web site offers a wide variety of information for Crime Victims and other PTSD persons.

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The counselor can work using a cognitive-behavioral model to develop strategies to interact and evaluate their client's process. Exploring intimacy and social support can be useful. It is not unusual for Central Americans, separated from their nuclear-family, or community-of-origin, to live with other nationals from other Central American countries. This community living can act as a family-of-choice or family-of-necessity, further providing support and personal validation.

Culturally competent counselors working with Central American immigrants may find themselves using the very same or similar counseling techniques used with any other ethnic groups struggling with PTSD. However, the culturally competent counselor focuses on the therapy process within a cultural milieu and from an experiential perspective. Approaching these problems in a step-phase fashion that is sensitive to the concerns of an immigrant population can motivate Hispanic, Central American clients to be hopeful and thrive in their new culture.

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