

# ADDICTION

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## Targeting trauma

**Judy Crane, Covington,  
Black, others, on addressing  
unresolved trauma (p. 12)**

Pictured: Judy Crane of The Refuge, A Healing Place





# To treat addiction, treat trauma

Experts see trauma-informed care as essential to prevent relapse

BY ALISON KNOPF

After a payment-driven hiatus of more than two decades, “trauma” is making a comeback in addiction treatment. Experts are saying now, as they did more than a generation ago, that treating addiction without treating underlying trauma in patients who are trauma victims is likely to lead to relapse.

Addiction treatment providers need to understand the dynamics of trauma, so that they can provide trauma-informed care, says Stephanie Covington, PhD, co-director of the Institute for Relational Development and a nationally regarded authority on gender-specific treatment. “If people have nothing else that is self-soothing, they’ll go back to drinking alcohol or using drugs,” Covington says. “We’re taking away their primary coping skills—alcohol or drugs.”

So it is no wonder that so many patients for whom trauma is the basis of their substance abuse end up relapsing, says Claudia Black, PhD, senior clinical and family services advisor for Central Recovery Treatment and Las Vegas Recovery Center. “Our relapse patients, otherwise known as treatment failures, are coming in because their trauma history has never been addressed,” Black says.

Covington and Black are two gurus in the trauma world, both coming from the early days of the 1980s when funded addiction treatment services were more comprehensive and were able to address more issues, including trauma.

People knew in the 1970s and 1980s that trauma was a core issue in addiction, and especially relapse, says Judy Crane, founder and executive director of The Refuge, A Healing Place, in Ocklawaha, Fla., who is a modern-day embodiment of the trauma movement. “Insurance is what happened” to trauma care, says Crane.

“The pieces about trauma and trauma history weren’t allowed; you didn’t get paid for that,” she says. “This is very unfortunate, because now we have a generation or two of folks who are really good with addiction, but not adequately trained in trauma.”

Eating disorders, sex addiction and self-harming behaviors all are “self-soothing behaviors” like drinking and using drugs are, says Crane. Trauma victims who stop drinking or using drugs might turn to these types of behaviors, she says. “That’s the core of relapse prevention—teaching



them how to live with very uncomfortable feelings.”

Crane started doing trauma work when she saw so many friends with long-term sobriety still be “in the morass of sex addiction or anger problems or eating disorders or psychiatric medications,” she says. “Something wasn’t working. Even if they weren’t relapsing on substances, their life wasn’t manageable. Several of my friends committed suicide after being sober seven or eight years. They all had terrible trauma and it just wasn’t addressed.”

### **Retraumatized by systems**

Addiction treatment that is not trauma-informed risks harming patients who are trauma victims, experts say. Larke Huang, director of the Office of Behavioral Healthcare Equity at the Substance Abuse and Mental Health Services Administration (SAMHSA), explains that trauma victims need to be empowered to direct their own care, or their histories actually could prevent treatment from working—and even could make treatment more harmful than helpful.

“Treatment providers need to recognize that this is a person who may have come out of a coercive relationship sometime in their past or present, and that they are coping with the trauma through alcohol or drugs,” says Huang, who is also lead for SAMHSA’s strategic initiative on trauma and justice.

Not being trauma-informed, in fact, risks “retraumatization,” especially for people who enter addiction treatment through child welfare or criminal justice settings where coercion is prevalent, says Huang. SAMHSA is working to encourage these settings to be trauma-informed, says Huang, noting that some of the trauma-specific treatments that were developed with SAMHSA support, such as Seeking Safety, came directly from the addiction treatment field.

In fact, SAMHSA is encouraging all service providers to screen everyone for trauma, and has been providing training in the public sector on trauma-informed care and specific trauma interventions. Its targets here have been community-based organizations that serve a safety-net population.

## What is trauma?

SAMHSA's definition of trauma is "very broad," says Huang, adding that she recently convened trauma centers to look at different definitions. A consensus meeting scheduled by SAMHSA for November 2011 was expected to work on getting "standardization," she says.

In addition to the personal traumas people experience in their own lives (child abuse, domestic abuse, etc.), there are the effects of historical and continuing trauma, such as the experience of Indians forced onto reservations and blacks forced into slavery.

Huang defines trauma as a stress that "causes physical or emotional harm from which you cannot remove yourself." Complex trauma is more narrowly defined as trauma "done by someone who is familiar to you on a repeated basis that you can't remove yourself from."

Post-traumatic stress disorder (PTSD) is not the same as trauma, Huang emphasizes. "Many people do not have PTSD symptoms but may still have a trauma history," she says. Because most traditional trauma screens are focused on PTSD, these screens tend to miss some trauma victims, she says.

There also are traumas associated with disasters such as hurricanes, mass shootings and, of course, the experience of combat. But trauma experts agree that people who can't cope with these situations usually have some other trauma history that events such as these trigger.

It turns out that people who are the least resilient to environmental trauma or combat are those with trauma histories themselves. "Lots of folks come in for treatment who were in 9/11, Columbine, or Katrina, and they absolutely fell apart," says Crane. "When we go back and look at their history, we discover that there was early abuse, or abandonment, or neglect."

The same applies to veterans. "I don't think any of our veterans have come home unscathed," Crane says. "But why are some able to come home and deal with PTSD more quickly than others? When vets come to us with very active PTSD, we find out there was so much else going on in their lives before they went."

Miles Adcox, CEO of Onsite, a Nashville-based 50-bed program offering six-day trauma workshops, says this phenomenon is particularly poignant in veterans coming home to what they feel are pointless marriages after service in Afghanistan or Iraq. "What they feel is that they don't know their partner anymore, and they blame the combat trauma," Adcox says. But after taking a careful trauma history, Onsite finds there was some other trauma that they hadn't dealt with in their lives.

"We might find something like Dad abandoning them when they were 8," Adcox says. "They realize through their trauma work that they deal with stress by running away—from their marriage, in this case."

Sometimes the trauma is not ill-intentioned—people get divorced, or have to work long hours—and their children might feel neglected and abandoned. In fact, adult children of "workaholic" parents could be the most difficult type of trauma patient because, says Adcox, they find it so hard to view something that society finds laudable—hard work—to be something that ended up hurting them. This makes the shame of addiction and relapse even worse, he says.

"They grew up in a perfect system that was really imperfect," he says. "When they get here there's so much shame attached, because they think the addiction is all their fault—they had quote unquote 'good childhoods.'" The parents might have supported the child "in every way they were supposed to," says Adcox, "but if they're not there emotionally, there's trauma."

Adcox says it is important for treatment providers to validate the abandonment that the child perceived. "So many people find the answer when they say, 'I didn't want a lot of things; I just wanted my Mom and Dad.'"

Crane agrees. "People are driven by the messages they receive," she says. "Abandonment and neglect are the greatest trauma any human being can experience, especially for a child."

And this is where the children of alcoholics movement dovetails with trauma: Alcoholic or drug-addicted parents create homes that discourage feeling, making

## A note about codependency

Once closely intertwined with the concepts of trauma and children of alcoholics in the addiction field, the codependency movement collapsed as a result of managed care—and it didn't come back.

"When managed care came down on addiction treatment in the 1980s, one of the first things they looked at was codependency treatment," recalls Onsite CEO Miles Adcox, adding that one insurance company "said it would be financial suicide to fund a condition that almost everybody has."

The insurance company "had a point," Adcox says. "We had watered down codependency so much, and eventually it got almost pop-culturalized."

their children believe they have no choice but to bury their feelings. Years later if that child is in treatment for addiction, professionals should seize the opportunity to help the patient validate these feelings as an adult.

## Fear of harming patients

However, many therapists are afraid to raise the topic of trauma with clients, says Crane. "This is a good ethical fear, based on concerns about how far their skills go," she says.

Crane is even more concerned about programs that say they do trauma treatment but aren't prepared or trained. "I applaud the people who say, 'We do substance abuse treatment and we don't touch the trauma.' That's ethical. It's inadequate, but it's ethical," she says.

But Crane stresses that they will do only good, not harm, if they just "provide a safe place to talk." And that, she says, is the precise skill set of the counselor—to be able to listen.

"All trauma survivors want is to be able to share the story," she says. "All we need to do is listen, to direct it, not to judge it, to create a place of safety, to be able to walk with them down that path, to say, 'I will hold this with you—let me help you heal.'"

Professionals who work with addiction-relapsing trauma victims frequently see

the same scenario, where nobody in the past has provided that safe place to talk. After repeated failures in addiction treatment, the patient finally gets to someone who asks questions that lead to the trauma being revealed, much to the patient's relief.

Consider the actual case of one client who had been on stimulant medication since age 7 and was still on it—and addicted to crystal methamphetamine—at 37. “He had a lot of anger issues, and he assumed his main problem was drug abuse,” recalls Crane. “We asked him, ‘What happened when you were 7?’ It turned out he had been sexually abused. Nobody had ever asked him what happened when he was 7.”

### The role of the counselor

At Onsite, about half of clients are in recovery from addictions; all are trauma victims. Onsite has three full-time clinical staff members and a network of 45 therapists around the country who rotate at Onsite.

“You can't do this level of intense work every week; it would burn you out,” says Adcox. “So we'll bring people in once a month, four times a year.” This allows Onsite always to have fresh staff, and it also allows participation from high-quality clinicians who can make more money in private practice than in a treatment center, he says.

Adcox believes the counselor's ability to engage the client constitutes the most important part of trauma treatment. “In addiction, if you can get someone to trust you, you can try any therapeutic model in the world, and whatever you try, it will work,” he says. “That phenomenon is even more prevalent in trauma work.”

Adcox adds that it is important for addiction clinicians to do their own trauma work as well. “I believe you can only take people as far as you have gone yourself,” he says. ■

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### Trauma and insurance



Insurance still doesn't pay for trauma-specific interventions, but it does cover the substance abuse part of treatment, says The Refuge's executive director, Judy Crane. The Refuge is in the network of Blue Cross Blue Shield and ValueOptions, but exactly what is covered depends on the individual's insurance plan. The 90-day program costs \$50,000. “That's a lot of money so it helps to have insurance to mitigate that,” says Crane.

Insurance won't cover Onsite at all because all that organization provides is trauma interventions, says CEO Miles Adcox. This is one reason there are so few trauma programs, he says. The cost is about \$500 a day; the core program, which lasts six-and-a-half days, costs \$3,150.

“We don't have the luxury to do long-term treatment,” says Adcox. “We really pack it in. And we don't treat people in crisis.”



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