# Integrating an Understanding of Trauma into Treatment for Women with Substance Use Disorders and/or HIV

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In the course of working with families affected by substance use and HIV, we are frequently confronted by behavior that we fail to understand. For example:

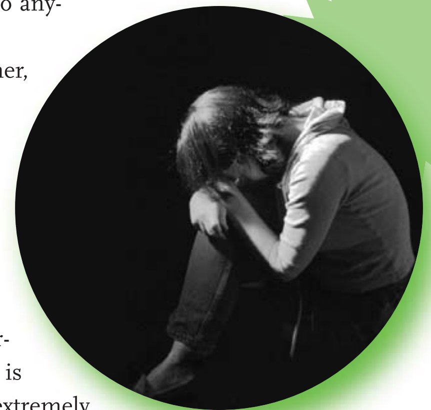
*Ms. A does not return for an appointment after her intake. Looking back, the intake worker remembers that she asked him to keep the door open during the interview. He said he could not do that because it would violate her confidentiality.*

*A social worker meets with the B family that has a service plan with Child Protective Services. Mrs. B seems very attached to and invested in her children, and appears to understand the service plan tasks and to have the ability to carry them out. Despite this, when the social worker returns, she finds Mrs. B has not completed any of the tasks.*

*Ms. C and Ms. D, who are living in a residential substance abuse treatment facility, are in a crowded kitchen preparing meals. Ms. C inadvertently steps backward into Ms. D, who becomes verbally abusive and enraged with her. When a staff member moves in to intervene, Ms. D turns her anger on her.*

*Ms. E has just completed an HIV prevention course and is extremely concerned about and aware of her risk for contracting HIV from her partner who is a former injection drug user. Despite this, she has been unable to ask her partner to use condoms.*

Understanding the impact of trauma on the lives of these women may make their behavior easier to comprehend and suggest appropriate intervention strategies. Ms. A was sexually abused by her father over a period of years, and becomes extremely anxious when alone with unfamiliar men. When the intake worker refused to leave the door open, she experienced him as not understanding and responding to her attempt to increase the safety of the situation. She, therefore, decided that this agency would not be able to help her, and did not to return. Mrs. B has a long history of physical abuse, beginning in childhood and repeated in adulthood by her husband. Her experience of life is that bad things happen no matter what she does, and that authority figures will use their power against her. She believes that Child Protective Services will take her children away no matter what she does, and is, therefore, not motivated to comply with her service plan. Ms. D, because of her abuse history, is physiologically over-reactive to anything that she perceives as a threat. When Ms. C bumps her, her body goes into "fight or flight mode" and she feels as if she is under attack and responds aggressively. With her emotions so dysregulated, she misreads the intentions of the staff member, perceiving her as another perpetrator. Ms. E's relationship is one in which her partner is extremely controlling. If Ms. E suggests that he use a condom, he is likely to respond with anger and, possibly, physical abuse. This is not something she feels safe to share in the HIV prevention group.



## The Impact of Trauma

It is not an exaggeration to state that a great majority of women in substance abuse treatment have a history of physical and/or sexual abuse, either as children or as adults (Najavits et al., 1997). The same can be said for women who are HIV positive (Wyatt et al., 2002). These

traumatic experiences have a profound impact on women's lives. Trauma can affect a woman's physiology, increasing the intensity of her "fight or flight" response to stressful events, as well as the length of time it takes her physical systems to return to normal after such events. These changes in physiology can prevent her from effectively using higher cognitive processes, such as reasoning, to sort out the meaning of a stressful event when it occurs (Van Der Kolk, 2006).

Traumatic experiences may also affect cognitive functioning, resulting in difficulty accessing memories at will or in flashbacks of memory of traumatic events when exposed to stimuli that are reminiscent of the events (Harvey, 1996). In order to protect herself from chronic abuse, a woman may develop the defense of dissociation, in which she splits off from certain experiences or "spaces out," leaving gaps in her memory or fragmented memories (Van Der Kolk & Fisler, 1995). Trauma can also affect cognitive functioning in a more diffuse way. When part of a woman's attention is always focused on being vigilant to the possibility of threat, less of her attention is available for whatever task she is doing. Trauma also affects the experience of emotions.

Trauma survivors often experience emotions as "all" or "none"; they either feel numb or overwhelmed, sometimes moving quickly between those two extremes (Van Der Kolk et al., 1996). In addition, the experience of physical and/or sexual abuse can change the way a woman sees herself (e.g., as "damaged goods"), the way she views others (e.g., that those who love you also hurt you) and the world (e.g., that the world is a dangerous place) (Veysey et al., under review).

Many of the behaviors and symptoms that service providers find problematic or difficult to deal with are behaviors that women have developed as a result of trauma. Most represent women's attempts to cope with unbearable situations (Elliott et al., 2005). For example, having lived in situations in which verbal or physical attacks have been the most common result of a "wrong" answer, trauma survivors will often choose their answers based on what they believe will help them survive, rather than having allegiance to some abstract value of truth. Trauma survivors may become either "overly" aggressive or "overly" passive in a situation which they experience as threatening, based on what has worked for them in the past. And they may have learned to use a variety of behaviors such as binging and purging, compulsive sexual behavior, self-harm, and/or self-medication, to deal with the emotional and physical pain that they have suffered. Women with a history of sexual abuse or domestic violence are also at increased risk for HIV infection. A study by Cohen et al. (2000) suggested a "continuum of risk" in which childhood sexual abuse increases the risk of victimization by partners as an adult and may lead to behaviors that increase risk of HIV infection.

The severity of the impact of physical or sexual abuse varies with the chronicity and severity of the abuse itself, the coping skills of the woman prior to the abuse, and the life circumstances of the woman prior to the abuse (Harvey, 1996). Women who are coping with chronic stressors, such as poverty, oppression, and pre-existing medical conditions are likely to be symptomatic (Norris et al., 2002). In some cases, the impact will be severe enough to warrant a mental health diagnosis such as Post-traumatic Stress Disorder, other anxiety disorders, or one of the many forms of depression.

Often, women begin to use drugs or alcohol to medicate the effects of abuse and this leads to addiction. Addiction, because it interferes with making safe choices, can lead to unsafe sexual practices, as well as to victimization. Within the context of drug use, women may experience physical abuse or trauma as a result of trading sex for drugs or prostitution (Fullilove et al., 1993). Many women are caught in an increasing cycle in which substance use leads to further victimization which leads to an increase in trauma symptoms which leads to more use of substances (Markoff et al., 2005). Contracting HIV results in emotional and physical consequences that further complicate this picture (El-Bassel et al., 2001). To effectively assist a woman in moving toward recovery, services must address substance use and mental health disorders and trauma in an integrated way that results in more effective self-care.

## Trauma-Informed Services

Trauma-informed services are designed on the basis of an understanding of the impact of violence and victimization on the lives of the individuals being served (Harris & Fallot, 2001). Many common procedures and practices in service settings are experienced as "re-victimizing" by trauma survivors (Elliott et al., 2005). These practices "trigger" women's trauma responses, which may result in withdrawal from services, "noncompliant behavior," increases in symptoms, and relapses to substances. Trauma-informed services are designed to minimize re-victimization and assist trauma survivors in understanding the impact of their traumatic experiences on their current life difficulties.

From 1998-2003, the federal Substance Abuse and Mental Health Services Administration funded the

Women, Co-occurring Disorders, and Violence Study. For two years, experts from across the country, including clinicians, researchers, consumers, and policymakers, worked together to develop consensus about the defining characteristics of trauma-informed, integrated care for women with co-occurring substance abuse and mental health disorders and histories of physical and/or sexual abuse. Following this, nine sites across the country implemented a study that compared the outcomes of trauma-informed, integrated care for this population with outcomes of similar women who received services as usual. At both six-month and twelve-month post-entry measurement points, advantages were found for trauma-informed, integrated care (Cocozza et al., 2005; Morrissey et al., 2005). A good deal of what is presented in this article comes from the experience of the authors in conducting the Women Embracing Life and Living (WELL) Project, one of the sites of that study in Massachusetts (Finkelstein & Markoff, 2004).

**Trauma-informed services are based on the assumption that trauma is central to the development of mental health and substance abuse disorders, as well as numerous other life difficulties.**

Human service providers benefit greatly from a thorough understanding of the impact of trauma on the various aspects of survivors lives: physical, cognitive, emotional, and behavioral functioning; beliefs about the world, the self, and others; as well as participation in relationships. Women, who are seeking services for life difficulties such as substance use and mental health disorders, sexually transmitted infections including HIV, domestic violence, or homelessness, should be screened for current safety from perpetrators, history of childhood and adult trauma, as well as trauma symptoms. However, it is important that those conducting the screening are able to do it in a trauma-informed way, and know how to respond to positive answers. Using screening questions as a first opportunity to educate women about trauma provides a good introduction to the questions, reducing consumer anxiety.

For example, if a woman is seeking treatment for substance abuse, the intake worker can say:

*It is very common for women with substance use problems to have experiences of sexual or physical abuse. I am going to ask you some questions about your history of abuse now. Your answers will help us to provide you with better services, and will not result in denial of services. However, you are free to refuse to answer any question.*

In conducting screening, it is best to keep the number of questions to a minimum and not ask for details of the traumatic events. Should a woman begin to "spill" or tell long detailed stories, it is best to redirect her, saying:

*I am sure that those events provide very important information about your current difficulties, and you will have the opportunity to discuss them during your treatment. Because talking about those events is upsetting, it would be better if you waited to discuss them further until your services are underway. For now, I just want to establish whether you have experienced certain kinds of abuse.*

However, if a woman discloses that she is currently in an abusive relationship, it is important to be certain that she is able to access safety planning, either by offering it as a component of trauma-informed services or by referral to a domestic violence agency.

Even when questions are asked in a trauma-informed way, it is likely that some survivors will not disclose, especially not immediately. Some survivors will disclose later, once trust has been established. Others will not disclose because it would not be safe to do so, or because they are unable to remember the traumatic events. Given the prevalence of histories of victimization for this population, we recommend that all consumers receive trauma-informed care, whether or not they disclose a history of trauma. Trauma-informed care will do no harm, and will benefit most women.

**The overarching goal of trauma-informed services is to restore a sense of autonomy and control to the survivor.**

The primary experience of victimization is one of helplessness—of having no control over your own outcomes. Restoring a sense of control is the primary goal of services for trauma survivors. Until some sense of control is established, trauma survivors often do not see the "point" of changing their own behavior or lifestyle because they do not believe it will have an impact on what happens to them or how they will feel.

In order for services to assist women in establishing a sense of control over their own lives, services must be grounded in an empowerment model. An empowerment model is based on a collaborative relationship between

the service provider and the service recipient in which both have something to offer. The service recipient is considered to be the expert on her own life. She sets her own goals and retains authority over her decision-making. The service provider assists the woman by locating resources and providing information and education. The service provider presents options and helps the woman explore possible consequences of different choices. Services are strengths-based, helping women to identify and make use of skills they already possess, as well as to build new skills (Browne, 1994). Agencies that provide services based on an empowerment model rely on consumer input to shape models of service delivery, and employ former consumers in as many roles as possible, because their "lived experience" is a valuable resource, and because they can serve as role models for current consumers (Prescott, 2001).

*Trauma-informed services help trauma survivors to learn safer coping skills. These include emotional self-awareness, emotional regulation, and making safe choices.*

### Trauma-informed services attempt to establish environments that feel safe to consumers.

Often, service providers are concerned that bringing up the issue of trauma will "trigger" survivors, resulting in relapse. Although this is a valid concern, being told not to discuss trauma has been experienced by women as re-traumatizing, replicating the experience in their families of origin in which they were not believed or were silenced. Environments feel safe to consumers when their experiences are validated and their real needs addressed. Judith Herman (1992), in her classic book, *Trauma and Recovery* identified stages of trauma recovery. The task of the first stage is establishing safety. During this phase, trauma survivors are encouraged to focus on learning to keep themselves safe in the here-and-now. This is the stage that most trauma survivors are in when they present for services. Service providers should, therefore, assist trauma survivors in accomplishing this task. Once this ability is established, trauma survivors will be ready to talk about their traumatic experiences in detail, usually in the context of individual therapy.

Trauma-informed services provide a relational context that is the opposite of an abusive one—one that is nurturing, empathic, authentic, and empowering. Trauma-informed services educate women about the impact of trauma on their lives. They help each woman to develop a story about herself that integrates all of her life experiences, including her victimization and her substance use and mental health problems. Trauma-informed services are designed to reduce re-victimization as much as possible, and to help each woman identify her individual "trauma triggers" and find ways to cope when triggered that do not compromise her safety.

### Trauma-informed services are based on the assumption that symptoms and behaviors are the result of trauma or attempts to cope with trauma.

When working with trauma survivors, one of the most useful questions a service provider can ask is, "How could this be a result of trauma?" Helping trauma survivors recognize their behaviors (i.e., self-medication, self-harm, aggression) as attempts to cope with the impact of trauma can help put them in a context that allows self-reflection and self-compassion, and facilitates recovery.

In a violent situation, a victim is best able to protect herself if she focuses her attention on the perpetrator. If she focuses her attention on her internal fear and terror, she will most likely be overwhelmed and unable to act. Trauma survivors often have learned to "block out" their internal experience of many emotions, unless the emotions are so overpowering that they break through the block. Therefore, trauma survivors often experience themselves as either numb or overwhelmed, with little transition between the two. Once overwhelmed, trauma survivors often do not know how to self-regulate, or reduce their own arousal. In this overwhelmed state, they lack access to higher cognitive processes, which could be used to help them clearly view the situation and make good choices about how to respond. In this state, trauma survivors often use coping skills that are unsafe or have negative consequences. Trauma-informed services help trauma survivors to learn safer coping skills. These include emotional self-awareness (monitoring, scaling, and labeling one's emotional state), emotional self-regulation (learning to raise or lower one's arousal level), and making safe choices (examining options and making choices based on likely outcomes).

Perhaps the most efficient way to educate trauma survivors about the impact of trauma on their lives and to teach safe coping skills is through conducting trauma recovery groups. These groups have the additional benefit of providing the opportunity for peer support and connection. A number of excellent curricula have been published, including *ATRIUM* (Miller & Guidry, 2001), *Beyond Trauma* (Covington, 2003), *Seeking Safety* (Najavits, 2002) and the *Trauma Recovery and Empowerment Model* (Harris, 1998). All of these groups are highly structured, present-focused, cognitive-behavioral, and teach coping skills (Finkelstein et al., 2004). They are easily integrated into residential or outpatient treatment programs. They can also be used as guides for conducting individual sessions, if the service context does not support running a group.

## Conclusion

Knowledge of the impact of trauma on the lives of women with substance use problems and/or sexually transmitted infections can help both service providers and consumers understand the reasons for behaviors and choices that appear to be self-defeating or even self-harming. Services that are trauma-informed provide an emotionally and physically safe environment in which women can identify, develop, and practice alternative ways to deal with stressful events. This process not only supports women in refraining from substance use, but enhances their overall capacity to practice good self-care.

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