

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Websites

Gift From Within (Resources Relating to PTSD, Trauma, and IPV for Survivors and Caregivers) <http://www.giftfromwithin.org>

National Coalition Against Domestic Violence <http://www.ncadv.org>

Institute on Domestic Violence in the African American Community www.idvaac.org

National Center on Domestic Violence, Trauma & Mental Health
<http://nationalcenterdvtrauma.org>

Women of Color Network <https://wocninc.org>

Publications (Books That Speak to the Trauma of Interpersonal Violence Within Families)

Born a Crime: Stories From a South African Childhood, by Trevor Noah, 2016

You Don't Have to Say You Love Me: A Memoir, by Sherman Alexie, 2017

Films

Fences (2016).

Hillbilly Elegy (2020, Netflix).

Videos

What Is Intimate Partner Violence? (2018; 1:43) CDC <https://www.youtube.com/watch?v=VuMCzU54334>

Intimate Partner Violence (2019; 3:25) AMAZE Org <https://www.youtube.com/watch?v=vK3RhRwMwIg>

COVID-19 and Intimate Partner Violence (IPV) (2020; 5:15) Veterans Health Administration
https://www.youtube.com/watch?v=1_g40WRfHso

I Broke My Silence: My Story of Domestic Violence (2017; 12:20) TED Talk
https://www.ted.com/talks/emma_murphy_i_broke_my_silence_my_story_of_domestic_violence?language=en

Domestic Abuse: Not a Gender Issue (2019; 12:35) TED Talk
https://www.ted.com/talks/andrew_pain_domestic_abuse_not_a_gender_issue

Men, Own Your Role in Domestic Violence (2017; 11:47) TED Talk
https://www.ted.com/talks/christan_rainey_men_own_your_role_in_domestic_violence?language=en

Domestic Violence: What Everyone Needs to Know (2018; 17:32) TED Talk
https://www.ted.com/talks/hannah_petrillo_domestic_violence_what_everyone_needs_to_know

Survivor Domestic Abuse Speaks Up—I Left on a Tuesday (2018; 12:48) TED Talk
https://www.ted.com/talks/chiara_lisowski_survivor_domestic_abuse_speaks_up_i_left_on_a_tuesday

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PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Websites

Gift From Within (Resources Relating to PTSD, Trauma, and IPV for Survivors and Caregivers) <http://www.giftfromwithin.org>

National Coalition Against Domestic Violence <http://www.ncadv.org>

Institute on Domestic Violence in the African American Community www.idvaac.org

National Center on Domestic Violence, Trauma & Mental Health
<http://nationalcenterdvtrauma.org>

Women of Color Network <https://wocninc.org>

Publications (Books That Speak to the Trauma of Interpersonal Violence Within Families)

Born a Crime: Stories From a South African Childhood, by Trevor Noah, 2016

You Don't Have to Say You Love Me: A Memoir, by Sherman Alexie, 2017

Films

Fences (2016).

Hillbilly Elegy (2020, Netflix).

Videos

What Is Intimate Partner Violence? (2018; 1:43) CDC <https://www.youtube.com/watch?v=VuMCzU54334>

Intimate Partner Violence (2019; 3:25) AMAZE Org <https://www.youtube.com/watch?v=vK3RhRwMwIg>

COVID-19 and Intimate Partner Violence (IPV) (2020; 5:15) Veterans Health Administration
https://www.youtube.com/watch?v=1_g40WRfHso

I Broke My Silence: My Story of Domestic Violence (2017; 12:20) TED Talk
https://www.ted.com/talks/emma_murphy_i_broke_my_silence_my_story_of_domestic_violence?language=en

Domestic Abuse: Not a Gender Issue (2019; 12:35) TED Talk
https://www.ted.com/talks/andrew_pain_domestic_abuse_not_a_gender_issue

Men, Own Your Role in Domestic Violence (2017; 11:47) TED Talk
https://www.ted.com/talks/christan_rainey_men_own_your_role_in_domestic_violence?language=en

Domestic Violence: What Everyone Needs to Know (2018; 17:32) TED Talk
https://www.ted.com/talks/hannah_petrillo_domestic_violence_what_everyone_needs_to_know

Survivor Domestic Abuse Speaks Up—I Left on a Tuesday (2018; 12:48) TED Talk
https://www.ted.com/talks/chiara_lisowski_survivor_domestic_abuse_speaks_up_i_left_on_a_tuesday

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CHAPTER 11

Trauma Survivorship and Disability

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CHAPTER OVERVIEW

This chapter focuses on the central role of disability in how people experience, deal with, and overcome traumatic experiences. Stress can emerge from a variety of health conditions (e.g., congenital disability, adventitious disability, chronic illness) and can be exacerbated significantly when one experiences trauma. Disability and trauma are not mutually exclusive experiences; in fact, they are not infrequently seen in tandem. Although trauma is frequently associated with large-scale natural events (e.g., hurricane, tornado, war), people with disabilities (PWD) experience various degrees of trauma due to pervasive societal discrimination, which can result in a number of psychopathologies necessitating affective type treatments. Despite trauma survivorship being common in nearly all societies around the globe, the evidence base has been thin, but the number of available interventions with promising options has been evolving quickly. The recovery from the effects of both disability and trauma is a process that requires an understanding of the diversity of factors that contribute to the trauma as well as the customization of treatments to individuals' life situations.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Define trauma and trauma survivorship;
2. Characterize the relationship between disability experience and trauma;
3. Outline the common sources and types of trauma experience with disability;
4. Discuss the relative significance of personal and environmental factors in trauma survivorship; and
5. Evaluate the evidence base on emerging counseling interventions for trauma survivors.

INTRODUCTION

An analysis of global disability concerns suggests that the impact of trauma, crisis, and disaster on persons with disabilities has emerged as an important trend in the international disability-related literature (Levers, 2011). Yet, theory and research-based literature regarding disability and trauma remains limited, despite the fact that these issues are often profoundly distressing. While people with disabilities (PWD) are at higher risk for traumatic experiences, limitations in health and rehabilitation services often hinder their access to support interventions they require to participate fully in society (Raoul et al., 2007). Disability trauma from work injury is prevalent in the United States, with nearly one in ten sustaining a serious injury-related disability (Haegerich et al., 2014). And, although most injuries can be treated and managed, survivors experience trauma from the larger challenges presented by adapting to the acquired disability (Zaloshnja et al., 2008). For people with developmental disabilities, trauma-informed care is a best practice due to their high trauma vulnerability in everyday settings (Rich et al., 2020). Trauma survivorship is associated with chronic distress long after traumatic events have ceased, affecting multiple life domains and areas of functioning (Shenk et al., 2012). In the next section, relevant trauma issues, as well as disability-related terms and concepts, will be defined and context for understanding the intersection between trauma survivorship and disability will be provided.

DEFINING RELEVANT TRAUMA ISSUES

The trauma experience typically follows “an event, series of events, or set of circumstances that is physically or emotionally harmful or life threatening and that has lasting effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; p. 7, see also American Psychiatric Association [APA], 2013). Moreover, trauma is not always the result of a singular event; it can occur and be intensified by recurring or new traumatic experiences. Recent updates to the *ICD-11* have also included a diagnosis of complex posttraumatic stress disorder (CPTSD; Barbano et al., 2019; World Health Organization [WHO], 2018), which typically occurs after prolonged (or chronic) exposure to distressing events (e.g., prolonged torture, child-maltreatment or child adversity, extreme domestic violence).

Posttraumatic Stress Disorder

Posttraumatic stress disorder (PTSD) is a clinical diagnosis that develops in some people in response to a traumatic experience and includes at least one of the following: (a) reliving the trauma (e.g., flashbacks, nightmares); (b) avoidance (e.g., avoiding persons, places, or things that might serve as reminders of the trauma); (c) hyperarousal; and (d) negative affect (Steenkamp et al., 2017). Most adults will survive at least one traumatic event in their lives (Bonanno & Mancini, 2012), but not all will experience PTSD.

Historically, trauma has been associated with the experience and survivorship of wars (Mullins, 1999). Necessarily, physical trauma and collateral disability were the archetypical forms of trauma. As a result of the necessity to provide quality medical interventions for these wounded military personnel, military, and large municipal hospitals contributed to the development of comprehensive trauma systems (Blaisdell, 1992). A trauma system is an organized multidisciplinary consortium providing and managing treatment beneficial to injured persons via the provision of timely and coordinated care (Mullins, 1999). Prior to the 1960s, trauma survivorship efforts of governmental agencies in the United States were focused mostly on reducing the country’s overarching burden of injury. The 1966 National Research Council (NRC), in conjunction with the National Academy of Sciences, issued a report entitled *Accidental Death and Disability: The Neglected Disease of Modern Society*. This report was the beginning of a nationwide effort to combat trauma and was a landmark publication highlighting the priority focus on surviving physical trauma. The overarching goal of this report was to translate the lessons learned from the wartime experiences with trauma

of this report was to translate the lessons learned from the wartime experiences with trauma into society at large. This report sought to stimulate innovative interventions for physical trauma and to improve treatment, especially in emergency departments. With the publication of this report, trauma became a political concern.

Trauma Survivorship

Trauma survivorship is described as being a “physical, emotional, and spiritual makeover” for a transformational and triumphant personal identity in the face of life-threatening adversity (Carr, 2008). The concept of trauma survivorship gained prominence from cancer survivorship research (National Cancer Institute, the American Cancer Society, LIVESTRONG: the Lance Armstrong Foundation, and the Centers for Disease Control and Prevention, NCI, ACS, LIVESTRONG, CDC, 2010), examining how people with a cancer diagnosis, erstwhile considered a death sentence, could recover their lives with lifestyle changes and triumphantly thrive with cancer instead of withdrawing into themselves, which would hasten their mortality (Bell & Ristovski-Slijepcevic, 2013). A robust corpus of literature exists documenting the phenomenon of psychological growth following suffering and trauma (Lerner & Blow, 2011; Tedeschi & Calhoun, 1995). Tedeschi and Calhoun (1996) framed this paradoxical process of positive psychological change following intense and highly stressful events as *posttraumatic growth* (PTG; 1996). PTG is not a mere return to pretrauma baseline of functioning; it is an enhancement of one’s previous self that does not result from the trauma per-se but from the resultant struggle to survive (Joseph & Linley, 2008; Tedeschi & Calhoun, 2004). A traumatic event(s) may be the catalyst to short-term or long-term disability, depending on survivorship competencies and resources. Resilience is one such resource. Broadly, resilience is defined as “the ability to adapt successfully to adversity, stressful life events, significant threat, or trauma” (Feder et al., 2019, p. 443).

Disability

The International Classification of Functioning, Disability, and Health (ICF) defines “disability” as “the outcome or result of a complex relationship between an individual’s health condition on the one hand and personal factors, and of the factors that represent the circumstances in which the individual lives” (WHO, 2001, p. 17). Disability, including both temporary and permanent impairments, can be the result of a traumatic experience; however, not all trauma results in disability. Much research addressing the effect of trauma on individuals does so from a somewhat myopic point of view, as it largely disregards the experiences of habitually disregarded segments of society (Suarez, 2013). Indeed, the construct of disability, as collateral to or from the experience of an event (or series of events) that would comprise trauma, is substantially influenced by aspects of culture, including discriminatory practices that deny PWD access to resources typically available to others in the community (Mpofu et al., 2012). PWD historically have been excluded from educational programs involving violence prevention, healthy relationships, and sexuality (McDaniels & Fleming, 2016). As a result of inadequate sexuality education and ignorance about safe-sex practices, PWD are at an increased risk of HIV and unwanted pregnancies (Doyle et al., 2020).

Discrimination and Disability

Disability-related discrimination relates to “any distinction, exclusion, or restriction of a person, based on disability, which has the purpose or effect of impairing or nullifying the recognition, enjoyment, or exercise of all human rights and fundamental freedoms in the political, economic, social, cultural, civil, or any other field” (Convention on the Rights of Persons With Disabilities, 2006, Article 2, Definitions). This concept includes direct and indirect discrimination, underscoring that disability rights are human rights.

Context

PWD face particular discrimination and neglect related to basic rights such as the right to food, shelter, or even to life. The scale of exclusion due to disabilities is often dramatic; for

example, globally, poor children with disabilities are less likely to receive early education, and many adults with disabilities have limited opportunities for competitive employment (WHO, 2001). In addition to the violation of human rights experienced by PWD because of practical impediments, foremost among them being negative attitudes, PWD may be denied their legal rights (e.g., employment, inclusive education; Konrad et al., 2013). Research has demonstrated that discrimination plays a role in exacerbating psychological distress in addition to increasing symptoms of PTSD, suggesting that social context is an important factor to consider when examining the well-being of socially marginalized groups (Matheson et al., 2019).

Most of the bias faced by PWD is premised on the three pillars of attitudinal, environmental, and institutional disability discrimination (Handicap International [HI] and CBM, 2006). These practices may lead to greater distress for PWD (both in severity of distress and duration) than the physical trauma of loss of a limb, sight, hearing, or any other physical trauma. Discrimination and exclusion of PWD is both a potential cause and effect of trauma. Following is a brief discussion of the different types of discrimination faced by PWD.

Attitudinal Discrimination

Stereotypes and stigma regarding disability exist across all cultures and permeate all social classes, even in the contemporary landscape that emphasizes disability as a human rights issue. Before discussing stigma and stereotype, we must define attitude. A classic definition of attitude is an evaluative psychological tendency that is either positively or negatively valenced (Eagly & Chaiken, 1993). Stigma, on the other hand, is inherently negative and is recognized by disapproval, shame, or disgrace, resulting in disadvantage and devaluation (Martin, 2010). This disapproval is based on any characteristic that is judged to be different from the norm (Bellanca & Pote, 2013), and stigma is manifested by stereotypes (Ohan et al., 2015), which are beliefs or cognitive schemas that characterize people into groups based on arbitrary characteristics of differentiation and results in discrimination (e.g., disability, race, ethnicity).

Among the various forms of discrimination, attitudinal discrimination toward PWD often creates the most difficult obstacles. Despite concerted efforts made through education and social inclusion policies, negative attitudes and perceptions persist (Barr & Bracchitta, 2015). Such stigma often arises from scapegoating or "othering" people who appear to be different in some way (these and related constructs are discussed more fully in Chapter 16). Among the number of deleterious outcomes, violence may be the result of objectification of PWD. Whereas numerous environmental circumstances (e.g., socioeconomic status, race, ethnicity) may render any PWD more vulnerable to violence, gender (e.g., female) is among the most salient characteristics associated with heightened vulnerability to interpersonal violence.

Environmental Discrimination

Despite decades of effort and the passage of scores of legislative acts to make communities accessible to all, PWD continue to be confronted with environmental barriers (Agaronnik et al., 2019). Attitudinal, environmental, and social factors continue to impede community participation (e.g., leisure, employment) and further marginalize PWDs (Anaby et al., 2013). Two forms of environmental discrimination that preclude accessibility of PWD exist: architectural (e.g., buildings, transportation, infrastructure) and social (e.g., presentation of information that is available to all). For example, transportation is critical for allowing PWD to fully participate in their communities, and when transportation is unavailable or inaccessible, access to community services is hindered (Hammel et al., 2015; McDaniels et al., 2018). It is not unusual for essential facilities, like those offering health and medical services, to lack accessibility for persons with mobility challenges, which can obviate receiving needed care and create unnecessary anxiety. Social inaccessibility, on the other hand, occurs when information is presented in formats that are not disability friendly (e.g., written only, computer-based).

Institutional Discrimination

Institutional Discrimination

Institutional discrimination is the societal mistreatment of a person or group of people based on stereotypical beliefs. This type of discrimination can be either intentional or unintentional. Examples include not hiring a PWD for a job or not allowing PWDs to participate in sexuality education.

Trauma Linked to Disability Discrimination

Over one's lifetime, PWDs are confronted with a variety of stressful events (e.g., perceptions of incompetence, social rejection) which may have significant deleterious effects (Hipes et al., 2016). The accumulation of these stressful experiences can become untenable and lead to additional psychological and emotional sequelae. In particular, discrimination and feelings of devaluation are among the most important "disability-relevant social stressors" (Brown, 2017, p. 99). These stressors are more typically observed in marginalized populations and higher levels of discrimination are associated with more severe depressive symptoms (R. L. Brown, 2014) and potentially PTSD (J. G. Allen, 2005).

Children with disabilities may be particularly susceptible to trauma, which includes physical abuse, sexual abuse, antipathy (i.e., rejection), psychological abuse (i.e., cruelty), emotional neglect, and physical neglect (Watts, O'Sullivan, & Shenk, 2018). Trauma in childhood is especially problematic because it can influence the course of psychological, social, and physiological development with effects often extending into adulthood. The experience of chronic stress in childhood has also been linked to increased risk for chronic illness and disability later in life along with the early adoption of maladaptive coping behaviors (e.g., substance abuse; Felitti et al., 1998).

CONTEMPORARY VIEWS OF TRAUMA SURVIVORSHIP AND DISABILITY

Contemporary understanding of trauma survivorship is more holistic and considers physical, psychological, and social aspects and how they interact to affect quality of life. Although not an inclusive list, trauma survivors may experience PTSD, generalized anxiety disorder, major depressive disorder (MDD) (Anwar et al., 2011; Warren et al., 2014), acute stress disorder (ASD), and dissociative disorders (Gold, 2008). Thus, consideration of the psychological, social, and postmodern effects of trauma survivorship is important.

Psychological Perspectives

PWDs have been marginalized for decades, which has led to cumulative historical trauma. Cumulative trauma results from natural or man-made disasters and involves injury to a group's identity (Saul, 2013). "The collective trauma works its way slowly and even insidiously into the awareness of those who suffer from it" resulting in loneliness and loss of self (Erikson, 1976, p. 154). Trauma as a psychological phenomenon is recognized in the works of Carlson (1997), among others, who regarded an event as traumatic if (a) an individual's perception of the event results in negative consequences (i.e., physical pain, injury, or death); (b) they perceive the sudden onset of the event as an immediate threat; and (c) the individual perceives the event as out of their control. Practically speaking, trauma survivorship consists of two factors, if one experienced the event (whatever it might be) as subjectively shocking (Solomón & Canino, 1990), and the event produced "symptoms of ... stress," including intrusion, numbing, and arousal (Norris, 1992, p. 490). In other words, survivorship of the traumatic event(s) presents a challenge to the individual's adaptive system, the mechanism for supporting psychosocial equilibrium within one's environment (Silove, 1999). Historically, the phenomenon of trauma has been associated more with disability experience and much less with adaptive competencies.

Sociological Approaches

Sociological perspectives, such as the work of Silove (1999), provide a systematic model to operationalize survivor adaptive systems. Silove considered five adaptive systems—safety, attachment, justice, existential meaning, and identity/role—which provide a homeostasis

attachment, justice, existential meaning, and identity/role—which provide a homeostasis between an individual and their environment. In reference to the safety system, experiencing a threat to one's health or life may initiate a psychobiological mechanism to ensure and preserve safety (e.g., fight or flight). In addition, connectedness or a sense of belonging is paramount to psychological well-being (Williams & Galliher, 2006), and the disruption of social ties results in a disturbance to one's interpersonal relationships leading to a host of detrimental mental health issues. For instance, in war trauma, specific tactics may be used to impact a person's sense of community negatively so that they feel alone and useless. Social connectedness not only moderates the effects of stress on mental health outcomes but also mitigates the impact of discrimination (Lee & Ahn, 2011). According to Nussbaum (2000), affiliation is one of the two essential capabilities that can "organize and suffuse all others" (p. 82). Social resources are critical to buffering stress and coping with problems and are associated with positive mental health outcomes (Umberson & Montez, 2010). Prior roles such as father, provider, and so forth, are diminished or eliminated. This disruption may result in actual (e.g., the death of a family member) or symbolic (e.g., self-worth) losses to which an individual must adapt.

Postmodern Approaches

Postmodern approaches (e.g., Stolorow, 2009) consider the experience of trauma a natural part of the human condition. According to Stolorow, "human beings would be much more capable of living in their existential vulnerability, anxiety, and grief, rather than having to revert to the defensive, destructive evasions" (p. 208). Postmodern perspectives on trauma consider trauma survivorship to be largely the result of environmental and societal domains (Anwar et al., 2011). When trauma survivorship is viewed in this manner, the potential of subsequent disability is based on the framework that (a) persons are not equally susceptible to or affected by traumatic experiences, (b) persons may or may not receive clinical care, and (c) clinical intervention posttrauma does not guarantee recovery in and of itself. Survivorship is compromised with continual distress and inadequate support within the recovery environment. Thus, providing psychosocial support to trauma survivors is critical for mitigating subsequent disability.

Human Rights Perspective

Trauma can be the result of natural or man-made circumstances. Of those that are man-made, physical, emotional, and psychological abuse are violations of one's human rights. International, civil, and human rights movements have cast trauma survivorship as a global issue, perhaps more than any other historical movement (Gruskin, 2004). For instance, protection from the experience of man-made traumatic events and the rehabilitation of survivors aligns with the United Nations' (1966) International Covenant on Civil and Political Rights (ICCPR). The ICCPR obligates governmental entities to respect the dignity and security of all persons via protection of physical integrity, procedural fairness in laws, freedom of speech and religion, and the right to political participation. This covenant is exemplified by related resolutions of the United Nations' organization such as the resolution in 1973 on Libya to protect citizens from predatory regimes threatening to murder citizens who hold contrary political ideology. As time passes, so-called second-generation human rights refer to survivors' entitlements to have access to basic necessities, whereas third-generation human rights entail respect of cultural values such as maintaining heritage, a sense of community, and the right to self-determination. These rights are These rights to human dignity are essential, should be guaranteed to every person, and must remain a top priority (United Nations, 1948). Thus, human rights norms and standards have provided a broad-based view to understanding trauma survivorship. Combining health and human rights in a public health framework provides a benchmark for the assessment of progress and the success or failure of trauma protection and safety policy implementation (Gruskin & Loft, 2002).

SURVIVORSHIP AND VICARIOUS TRAUMATIZATION

SURVIVORSHIP AND VICARIOUS TRAUMATIZATION

The psychological effects of traumatic events are not limited to the one who experienced the event; anyone who has a relationship with the survivor is also susceptible, including those who provide services to the individual (e.g., first responders, counselors). Figley (1995, p. 573) posited that stress/trauma is a “normal and natural byproduct” of being in relationship with traumatized people. Vicarious traumatization (VT) consists of a variety of psychological effects (e.g., nightmares, intrusive thoughts) experienced by repeated exposure to other people’s trauma, which can lead to long-term consequences to both involved (Pearlman & Saakvitne, 2013). VT is constructed over time and insidiously invades one’s everyday life. Secondary traumatic stress, another closely related phenomenon, is defined as a PTSD-like syndrome (Melvin, 2015). Family members are also at risk of developing symptoms of PTSD through the vicarious experiencing of the event of their loved one. Historically, a diagnosis of PTSD was given only to the one who was actually exposed to the event; however, with the revisions of the *DSM-V* (APA, 2013), the diagnostic criteria allow for “learning that the traumatic event(s) occurred to a close family member or close friend” (APA, 2013, p. 271). The inference is clear—traumatic events and PTSD can affect anyone who interacts with the traumatized individual.

Congenital Disability

The process of childbirth has been described as an existential event that affects the entire family constellation (Nilsson et al., 2010). When childbirth is traumatic (e.g., the discovery of a congenital disability), families commonly experience both psychological and emotional trauma (Obeidat et al., 2009) with some describing their experience with the pediatric ICU as “being in hell” (Widding & Farooqi, 2016, p. 160). Most parents are ill-equipped to assume the myriad responsibilities associated with ensuring the child’s medical needs are met, and they frequently fail to attend to their personal needs (Bishop et al., 2019). Parents may dwell on the traumatic experience (e.g., guilt, blame, anxiety, depression) and blame themselves for their child’s condition. Once receiving the unwelcomed news of a diagnosis, parents may react with ambivalence, denial, anger, guilt, and sorrow (Barnhill & Barnhill, 2010).

Acquired Disability

Despite the reactionary similarities between adjusting to a family member with a congenital disability and one who acquires a disability, one stark contrast is, with an acquired disability, families mourn the “loss” of the family member while simultaneously being introduced to the “new” person within the family unit. Acquired disability typically arises from traumatic events such as accidental injuries as in motor vehicle accidents (MVA), falls, and war injuries; therefore, families not only have to deal with the immediate effects of trauma but also with the resultant, long-term consequences of disability. Like families who have a child born with congenital disabilities, those who are confronted by an acquired disability are thrust into uncharted territory replete with dramatic family role changes, financial uncertainty, unpredictability, stress, and anxiety that they were unable to prepare for (Degeneffe, 2015). The family becomes the primary source of affective and caregiving support (e.g., advocacy, service coordination, daily living needs) (Degeneffe & Burcham, 2008). The case of Sue, in Box 11.1, is illustrative.

BOX 11.1

Clinical Vignette: The Case of Sue

You are working as a vocational rehabilitation counselor at the U.S. Department of Veterans Affairs. You received a supported employment referral for Sue, a 56-year-old female Caucasian veteran. With supported employment, participants have work reentry support of job coaches both onsite and also from a facilitator (or case manager) of a vocational rehabilitation agency. Sue has a diagnosis of paranoid schizophrenia and military sexual trauma.

During your initial consultation meeting, Sue described her interests and preferences for work. She also talked about her prior job as a secretary. Sue explained that she needed to quit her last job because she was having problems getting along with her male coworkers. Sue discussed how she has felt uncomfortable around men since she was sexually assaulted when she served in the military 15 years ago. Currently, she feels worried about her male neighbors because she believes that they are attracted to her and may try to pursue her. Consequently, Sue has not been sleeping well.

You accept Sue into your supported employment program, but you plan to recommend that she seek counseling for her current stress and anxiety.

Reflection Questions

1. How do you use the supported employment counseling to address Sue's current stress and anxiety?
2. What other counseling intervention options would be appropriate for Sue and why?
3. What is the evidence for the interventions you recommend?

RESEARCH ON TRAUMA SURVIVORSHIP AND DISABILITY

Traumatic events are complex and challenging to study (Norris, 1992). Prior trauma studies have relied on small, homogeneous samples, often focusing on only one particular event (e.g., traumatic brain injuries [TBI], stroke) at a time. Such a narrow method of evaluation has limited knowledge gains in the frequency and severity of traumatic events that occur in society. Even when considering the limitations of previous research, a theoretical/empirical understanding of the construct of trauma is important for several reasons. As noted previously, clinically, exposure to trauma is linked to dissociative disorders, depression, anxiety, substance abuse, personality disorders, and psychosis (Anwar et al., 2011; Gold, 2008; Warren et al., 2014). Exposure to trauma has been linked to various health-risk behaviors such as childhood physical and verbal abuse (Williamson et al., 2002); spousal, sexual, physical, and emotional abuse (Dube et al., 2003); and smoking, alcohol abuse, and high-risk sexual behavior. The case of James, in Box 11.2, is illustrative.

BOX 11.2

Clinical Vignette: The Case of James

James is a 35-year-old African American man who returned home from combat in Afghanistan 6 months ago. He is seeking counseling services from the local Veterans Administration because of PTSD. While in Afghanistan, James obtained an injury caused by an explosion and had to have a right below-the-knee amputation. He recovered at the local veterans' hospital and now uses a prosthetic leg for mobility. During the clinical interview, James mentioned that upon returning home, he and his wife of 5 years are arguing a lot. He finds himself constantly losing his temper with her. James drinks about four to six alcoholic beverages per day to cope with stress. He states that drinking helps him to cope with the images of combat scenarios that haunt his dreams and the amputation he endured.

Reflection

1. What other background information may be needed before developing a treatment intervention to help James?
2. Considering courtesy trauma, what issues may James's wife be experiencing?
3. Choose one counseling intervention that has been proven efficacious in helping persons with war-related PTSD. What are the benefits, risks, and considerations associated with using the intervention?

When examining the relationship between trauma exposure and physiological/psychological maladjustment, there is, at times, a direct causal relationship; however, the overall relationship is much more complex (Morrison et al., 2003). For instance, in the case of multiple traumatic experiences, exposure to trauma may make one more susceptible to future trauma (Gold, 2008).

Trauma Centrality, Identity, and Self-Efficacy

Research emphasizes trauma centrality, when the memory of a traumatic occurrence can become a central part of a survivor's identity (Rubin et al., 2008). Survivor identity is negatively correlated to PTSD symptoms in soldiers exposed to combat stress, even when controlling for depression and dissociation (A. D. Brown et al., 2010). The implications of this study suggest that trauma centrality may contribute to the development and continuation of PTSD.

Additionally, a meta-analysis (Luszczynska et al., 2009) provides evidence in support of an association between self-efficacy and PTSD symptoms on health-related outcomes such as distress, anxiety, and depression among survivors. Effect sizes were medium to large, in terms of cross-sectional studies of self-efficacy on general distress, severity, and frequency of PTSD ($r = -.36$ to $-.77$).

Premorbid Personality Characteristics and Posttraumatic Stress Disorder

The biopsychosocial impacts of PTSD are well-documented; what is less clear are the premorbid factors that increase the likelihood of clinically relevant PTSD. Studies have investigated the development of PTSD following the events of 9/11 (DiGrande et al., 2008) and in military personnel who were deployed to missions in Iraq and Afghanistan (Jacobsen et al., 2015) and reported that only 12.6% and 6% reported symptoms consistent with PTSD, respectively. Among the proposed explanations for these curious findings are the differences in premorbid vulnerabilities (e.g., genes, epigenetics, personality characteristics; [M. T. Allen et al., 2019]). Personality characteristics that are positively correlated with PTSD include: (a) trait anxiety (Phipps et al., 2009), (b) behavioral inhibition (Tyrka et al., 2008), (c) emotional dysregulation (Weiss et al., 2019), and (d) type D personality (i.e., negative affect, social inhibition; M. T. Allen et al., 2018). Other contextual factors that are positively associated with an increased propensity to develop PTSD include prior trauma, prior psychological adjustment issues, family history of psychopathology, perceived life threat during the trauma, posttrauma social support,

peritraumatic emotional responses, and peritraumatic dissociation (Ozer et al., 2003). Ozer et al. (2003, p. 31) suggest that “the specific processes by which these factors may serve to influence the development of PTSD remain largely unexamined” and “further specification of the intervening as well as directly explanatory variable would point to areas of opportunity for intervention and possible attenuation or prevention of the development of PTSD.”

In terms of future research, it is necessary not only to continue to investigate the association between traumatic experiences and physical/psychological impairment (Gold, 2008), but more importantly, to identify protective factors and evaluate promising strategies for enhancing them. Specifically, researchers should investigate the factors (e.g., resiliency, social support) that lead persons exposed to trauma to experience or not experience the adverse ramifications. Further exploration is needed, because researchers found that participants receiving treatment for PTSD who completed trauma-related questionnaires reported more feelings of sadness compared to participants completing nontrauma-related questionnaires (Ferrier-Auerbach et al., 2009). Lastly, current research specifically relating to PTSD resulting from the experience of child-maltreatment is quite limited (Ehring et al., 2014). In a review of over 40 randomized controlled studies examining the impact of effective counseling approaches for PTSD, only 10% examined the effectiveness of these approaches for individuals with child-maltreatment histories (Cloitre, 2009), emphasizing that current approaches may not effectively address issues that child-maltreatment survivors might experience (i.e., interpersonal disturbance and emotion dysregulation).

CURRENT PRACTICES IN TREATING TRAUMA IN SURVIVORS WITH DISABILITY

As the field of disability studies has progressed from the medical model of disability to the more comprehensive ICF model, the field of trauma studies has recently begun to broaden the focus of PTSD interventions from the singularly shortsighted fixation on individual characteristics to appreciating the links between individual experiences and their macrosystem (Bonnar-White et al., 2018). This purposive shift toward a holistic approach to trauma survivors, and those who have comorbid disabilities, allows for complementary interventions that include the contributions of oppression and marginalization. When one is from more than one marginalized group (e.g., trauma survivor, one with a disability), the experiences of trauma qualitatively differ from what one from a dominant group experience (Bryant-Davis, 2019).

Trauma-informed care (TIC) is widely accepted as the necessary framework when working with individuals who have experienced trauma. TIC is a holistic approach that incorporates the effects of trauma on psychosocial functioning (SAMHSA, 2014). TIC is not a form of trauma-focused therapy; rather, it is a general orientation for service delivery that views the individual's issues through the lens of their traumatic experience (S. M. Brown et al., 2012) to foster the development of adaptive coping in the context of oppression. Clinicians who provide trauma-counseling interventions to individuals with disabilities face challenging dilemmas not only about how to provide evidence-based treatment to more than one condition, but which one should be the focus. Most PTSD or trauma counseling theories and techniques are applicable to treating trauma in PWD. However, intervention strategies, resources, or facilities may need to be modified to meet the unique needs of people with specific disabilities.

Trauma-Focused Therapies

Over the past two decades, PTSD and its associated trauma-focused treatments have received a great deal of attention. Despite the interest in efficacious interventions, no treatment has proven to be superior. Several meta-analyses have reported that there is no difference in efficacy between various types of trauma-focused treatments (Australian Centre for Posttraumatic Mental Health [ACPMH], 2007; Bisson & Andrew, 2009; Seidler & Wagner, 2006). However, one factor is clearly associated with therapy completion and positive

2000). However, one factor is clearly associated with therapy completion and positive outcomes—the therapeutic alliance, which may be critical when working with individuals with trauma histories who may have trust issues (Watts, O'Sullivan, & Chatters, 2018). Along with improved diagnostic criteria and several notable trauma-inducing events (e.g., Iraq/Afghanistan conflicts, 9/11), a number of promising therapies to treat PTSD have evolved.

Currently, trauma-focused approaches (e.g., trauma-focused cognitive behavior therapy [TF-CBT]) are promoted as first-line treatment for PTSD (American Psychiatric Association, 2004; ACPMH, 2007), and the Department of Veterans Affairs and the Department of Defense (2017) have issued clinical practice guidelines recommending several specific TF-CBT interventions: cognitive processing therapy (CPT; Resick et al., 2016), prolonged exposure (PE; Foa et al., 2007), and Eye Movement Desensitization and Reprocessing (EMDR) first-line therapy (Shapiro, 2017). Collectively, the symptoms of PTSD are amenable to interventions, but roughly one-third of people have symptoms that are somewhat unresponsive to traditional trauma-focused options (Watkins et al., 2018). Although not specifically trauma-focused (debate continues regarding the necessity of “trauma-focused” labels), a variety of PTSD treatments have been studied and can be successfully “delivered in a trauma-focused framework” (Schnurr, 2017, p. 57).

Alternative and Complementary Interventions

Complementary and alternative medicine (CAM) are practices that augment traditional medical care but are unlikely to become first-line treatment options (Wynn, 2015). A variety of current nontrauma-focused treatments hold promise, such as affective and interpersonal regulation, yogic breathing, mindfulness training, acupuncture, and behavioral activation (Jakupcak et al., 2006). Further research is warranted to continue to investigate the efficacy of these new interventions for trauma.

Treatment Outcomes With Co-Occurring Conditions

Although trauma alone can result in significant psychosocial challenges, comorbidities frequently accompany a PTSD diagnosis (Kang et al., 2019). More than one-half of all people diagnosed with PTSD have co-occurring anxiety, mood or substance use disorders (SUD; Pietrzak et al., 2011), which may contribute to increased disability and poor health outcomes (Schlenger et al., 2015). Challenges related to treating individuals with PTSD and SUD, for example, include more severe symptomatology and treatment dropout (Norman et al., 2012). Positive comprehensive trauma treatment delivery outcomes with people with co-occurring trauma and disability have been reported. For instance, a collaborative care (CC) pilot intervention, which reduced symptoms of PTSD and alcohol abuse among inpatients with physical injuries (Zatzick et al., 2004), was shown to be effective compared to the control (nontreatment condition) group. CC is a disease management strategy that integrates evidence-based mental health interventions into medical care. Collaborative interventions have the potential to improve rehabilitation from trauma and disability.

Impact of Disability Service Delivery Services

Physical, psychological, and vocational functioning often become personal barriers facing working-age adults with disabilities who seek employment opportunities. With respect to employment opportunities for PWDs resulting from trauma, psychosocial factors play a significant role even though the exact impact of such factors on employment status is difficult to determine (Smeets et al., 2007).

Although PTSD or trauma survivorship counseling interventions are appropriate for treating trauma in PWDs, there is limited understanding of the unique treatment needs for individuals with disabilities. Researchers should continue to investigate service delivery models for individuals with co-occurring physical disabilities (e.g., spinal cord injury, traumatic brain injury) and trauma (Zatzick et al., 2001). Moreover, clinicians should aim to develop evidence-based interventions that could assist individuals who experience trauma from the diagnosis of a chronic illness or disability (e.g., HIV, multiple sclerosis, Parkinson's

from the diagnosis of a chronic illness or disability (e.g., HIV, multiple sclerosis, Parkinson's disease). To elaborate, these interventions are important for persons with co-occurring trauma and disability in order to improve rehabilitation outcomes, specifically in the area of socioeconomic participation.

COUNSELING IMPLICATIONS

Addressing issues related to disability and trauma requires a bipartite approach (Cowles et al., 2020), one that addresses both the physical trauma of having acquired a disability and the psychological trauma of having experienced discrimination, marginalization, and exclusion. The use of this approach means both mainstreaming of disability into all strategic plans as well as supporting specific disability initiatives for the empowerment of PWDs.

The type of service provision model that is used typically influences the approach that is applicable in providing disability support services. The outdated charity model, which sees PWD as victims of their impairments and consequently in need of special services and care in special institutions, has seen the creation of special institutions that remove PWD from communities. This approach discriminates against PWD and does not address trauma that is caused by discrimination. The medical model tends to consider PWD as clients who need fixing to make them "normal," and places PWD into the passive mode; all the while, rehabilitation "experts" make all the decisions for them, thereby, again, not addressing the disability trauma caused by discrimination. The social model, the multidimensional model, and the political perspective model tend to address issues of disability mainstreaming, inclusion, participation of PWD, and involvement of disabled people's organizations in empowerment programs. In this regard, the emphasis is not only on medical rehabilitation, but rather, it is on the support services that are required by PWD to participate fully in family and community activities and to access equitable services. The greatest implication for counseling relates to the aforementioned types of systemic service-provision features that may have profound effects upon PWD who have experienced trauma.

CONCLUSION

Disability and trauma are both complex, multifaceted constructs, and causation directionality is likely bidirectional. Conceptualization of trauma has evolved over time to emphasize contextual factors that influence competencies and strength that contribute to the outcomes of traumatic experiences. Human rights approaches provide a transcultural understanding of trauma experiences that are important for policy on protections from trauma and necessary resources for survivors. The research evidence suggests that disability (e.g., PTSD) from trauma experience and survivorship is influenced by a variety of factors (e.g., social support, premorbid functioning). Evidence is accumulating on the efficacy and effectiveness of trauma-focused therapies, along with a host of promising options for treating trauma survivors with disability. Recovery from both trauma and disability are not events; they are journeys that often last for a lifetime. Survivorship is an inclusive concept for understanding the lived experience of trauma and also the recovery process.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

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CHAPTER 12

Older Adults' Health Resourcing

ELIAS MPOFU

CHAPTER OVERVIEW

This chapter focuses on aging as a natural process that affects every one of us. It provides an interdisciplinary overview on how older adults' health needs and the relationships for them change with the aging process, conspiring their biopsychosocial vulnerabilities and assets during the later life years. Most importantly, it discusses the developmental aspects of aging, the meaning of age, issues affecting older adult people, and the significance of relationship support to successful aging. In doing so, the chapter surveys the demographics of aging and the evidence from aging-related research important to the health resourcing of older adults. Finally, the chapter considers a case illustration on the implications of aging to healthcare resourcing from family, cultural, and social policy perspectives.

researching from family, cultural, and social policy perspectives.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Define key terms that are relevant to aging, along the life course and in the context of health and function;
2. Outline the significance of relationship transitions associated with the aging processes and outcomes;
3. Examine how health and function in old age relates to practices for successful aging;
4. Evaluate the role of demography of aging and interdisciplinary perspectives, in order to understand vulnerabilities from the aging process and practices to mitigate those vulnerabilities; and,
5. Explain the role of family and support systems as well as living arrangements for successful aging in older adult populations.

INTRODUCTION

The global older adults population aged 60 years and above is projected to increase by 12.5% to approximately 2 billion in 2050, representing one in five people, world-wide (United Nations' World Population Ageing [UNWPA], 2012; United Nations Population Fund [UNPF], 2019; World Health Organization and the National Institute on Aging [WHO & NIA], 2019). The population of older adults aged 65 and older in the United States will double between 2011 and 2050, and that of the "oldest old," aged 85 and older, will increase tenfold in the same period (Administration on Aging, 2010; WHO & NIA, 2019). Yet, "many older people today experience much poorer health trajectories" from preventable conditions and which could at least be "delayed by engaging in healthy behaviors across the life course" (WHO, 2017, p. 6). The WHO advocates for "age-friendly help to foster Healthy Ageing in two ways: by supporting the building and maintenance of intrinsic capacity across the life course, and by enabling greater functional ability so that people with varying levels of capacity can do the things they value" (p. 6). With aging, people's health becomes more complex, requiring integrated healthcare relationships beyond those designed for acute conditions.

While many older adults will experience health, vitality, and longevity unknown to previous generations (Butler, 2009), they also will age with or into disability, immune compromise, chronic inflammation conditions, and frailty (Beard et al., 2016; Franceschi et al., 2018). For these reasons, the longevity gained by many older adults also places them at elevated risk for trauma from conditions associated with the aging processes and the health relationship qualities that they may lack in mitigating those aging processes (O'Neill, 2017). Quite regrettable is the fact that older adults are at elevated risk for abuse and neglect by carers, who may be family and/or other clinicians (Falk, 2012; Yon et al., 2017). Moreover, in the presence of diminishing physical and financial resources, the quality of health relationships of older adults is critical for their successful aging. Successful aging refers to achieving a desired health-related quality of life, even with functioning limitations, by maintaining one's self-efficacy (Cosco et al., 2014).

This chapter discusses relationship health qualities among older adults, which is important for their wellness in the face of decreasing health and function. First, it describes the major aging process conditions for which older adults would require health support for successful aging. Second, the chapter addresses the health relationship vulnerabilities of older adults, including from risks for abuse and maltreatment, and considering diversity among older adults as important for understanding their care needs with aging process conditions. Third, this chapter proposes health relationship resourcing approaches at the personal, family, community, and policy care levels for successful aging.

AGING PROCESS HEALTH CHANGES

Older adults experience significant assaults on their physical, mental, and social health from the aging process. These assaults on health may occur in parallel, with devastating impacts on well-being. They also may occur variably among older adults in terms of timing, intensity, or severity. To add to the complexity of managing aging-related processes, their occurrence in any one older adult is not entirely predictable, and when they do occur, the outcomes may vary, depending on type, timing, and presence of preexisting conditions. The aging process health of older adulthood requires multilayered interventions to mitigate personal-lifestyle, sociobehavioral, medical, and environmental health issues, often a combination of interventions. Among the best documented of health traumas of old age include immune suppression immunosenescence and inflammaging, cancer, neurodegenerative conditions, physical frailty, and sarcopenia.

Immunosenescence and Inflammaging

Older adults have diversity in terms of their immune functioning, which is important for their relationship health, as far as they might require the support of family and other caregivers. Immune function declines with aging, a process called immunosenescence. This process varies widely among older adults, and some have earlier and pervasive onset of immunosenescence, while others have later age onset of immunosenescence. Moreover, of those presenting with immunosenescence, some may be with low to mild forms or more severe forms. The rate of decline in immune bodily capabilities would vary among older adults, and may change within older adults influenced by their evolving biological functioning (such as the body's ability to engage in cell repair), as well as lifestyle and life situation demands (Franceschi et al., 2018). The concept of life situation is a person-centric and context-sensitive way to address real world, everyday activities in which individuals engage and that they perceive to be normal or routine practices in the home or community (Jurczyk et al., 2015).

Indicators of immunosenescence include higher vulnerability to infections and to inflammaging, which is an inflammation syndrome. The immunosenescence is associated with the lower immune white blood B cells and T cells for recognizing and fighting invader microorganisms like viruses and bacteria that may enter the body in various ways. With the aging process, the production of white blood cells, which detect a pathogen in the body systems, declines, and the body is less capable to detect and neutralize the invading microorganism, which could be COVID-19, for example. Elevated immunosenescence is associated with chronic inflammation syndrome (inflammaging) or persistent low-grade inflammation, degrading the immune response from the body systems to infections (Baylis et al., 2013). While "a moderate inflammation is beneficial and fundamental to activate a [healthy] response to a stress," chronic and elevated inflammation is detrimental (Castellani et al., 2016; Franceschi et al., 2018, p. 5). Older people are susceptible to infectious disease and may have one or more chronic or infectious diseases, making them especially vulnerable to additional infectious diseases (WHO & NIA, 2019) (also as demonstrated by the morbidity and mortality from the global COVID-19 pandemic).

With the aging process, risk for chronic inflammation syndrome is exacerbated by lifestyle issues such as weight gain and mental distress as well as poor access to timely healthcare (Bosma-den Boer et al., 2012). Chronic inflammation is associated with aging autoimmune diseases, such as rheumatoid arthritis, ankylosing spondylitis, osteoarthritis, systemic lupus erythematosus, psoriasis, inflammatory bowel diseases, multiple sclerosis, and others (Franceschi et al., 2018). Chronic inflammation is also associated with cardiovascular, respiratory, and renal dysregulation. The health support needs for older adults would vary by their location on the immunosenescence spectrum (low, high); inflammaging status (episodic, chronic); lifestyle factors; and access to timely healthcare services. Yet, there is a tendency by the general population to treat older adults as necessarily immune compromised, while also not recognizing the diversity in their immune function that explains differences in their health outcomes.

Cancer

Cancer

While cancer occurrence is a life-long potential, in older adults the risk is elevated (Parry et al., 2011). With the aging process, the chances increase significantly that transforming mutations might occur; this is likely due to the damage that results from allowing cells to progress into malignancy and to metastasize (DeNardo et al., 2010). This effect probably transpires in the presence of an elevated level of inflammaging, from a compromised immune response attempting to manage cancerous cells (Grivennikov et al., 2010). The presence of immune inflammatory cells is associated with tumor growth and cancer cell proliferation, as well as invasiveness. As previously noted, inflammaging is a risk factor for a variety of health conditions of old age; the higher prevalence of inflammaging with aging would explain the association between cancer and old age. Because the inflammaging response is universal in humans, theoretically, it would portend cancer type occurrence at some point in advanced age for some older adults. Of course, learning of a cancer diagnosis is distressful for most individuals and may be traumatizing to many.

A significant proportion (66%) of older adults are cancer survivors, so they can expect to be alive in 5 years (Aziz, 2007). Cancer survivorship refers to lived health quality with a history of cancer diagnosis navigating the complexities of treatment phase care, optimizing the physiological, psychosocial, and functional health outcomes (Feuerstein, 2007; Mohile et al., 2016). Older adult cancer survivors may experience organ senescence or the failure of compensatory mechanisms, with the passage of time, from acute organ toxicities such as radiation pneumonitis, chronic congestive heart failure, inflammaging-related neurodegenerative conditions, and malignancies. Older age care survivors require extensive health support relationships to sustain a meaningful life (Rowland et al., 2006).

Neurodegenerative Conditions

Alzheimer's disease (AD) and Parkinson's disease (PD) are two neurodegenerative conditions associated with the aging process (Boyko et al., 2017; Nelson et al., 2012). Their onset may be incipient and may include later-stage clinical manifestations, with signs of dementia, including memory impairment, time-space disorientation, and difficulties in performing erstwhile basic and/or instrumental activities of daily living. About 25% to 30% of older adults, over 85 years of age, will have dementia (WHO & NIA, 2019). One in eight Americans has Alzheimer's disease, and close to half of all people older than 85 years, the fastest growing segment of the U.S. population, has Alzheimer's disease (Alzheimer's Association, 2011). At mild-to-advanced stages, AD and PD would be traumatizing to the older adults and carers, requiring relationship resourcing and resilience. Certain bacterial infections are hypothesized to activate the pathways involved in neurodegeneration and AD, in the presence of cerebral inflammatory responses (Houeland et al., 2010). PD appears to be associated with accelerated aging, affecting specific neurons in the brain, and to be on a continuum between physiological aging and neurodegenerative age-related motor disorders (Franceschi et al., 2018). PD also appears to be associated with neuroinflammation and perhaps even result from environmental stressors (Codolo et al., 2013). Health relationship demands with AD and PD are extensive and unrelenting; they are further compounded by the loss of personal agency, over time, among the afflicted as well as by resource depletion risk of the carers (Kalaria et al., 2008; Kim et al., 2007; Riggs, 2001).

Physical Frailty and Sarcopenia

Frailty is characterized by a loss of physical functions of agility, energy depletion, poor hand grip, and also a poor response to, and recovery from, environmental stress (Aguayo et al., 2017). Older adults with frailty have a high risk for falls, which could be fatal. However, frailty is peculiar as it displays a wide spectrum of phenotypes, depending on the criteria that are considered for its definition, as well as the age range of the subjects studied. Frailty in earlier-age older adults can be treated with physical exercise and nutrition supplements (Michel et al., 2015). Frailty from low-grade inflammaging may be a case of accelerated aging and may be reversible with appropriate treatments (Fried & Ferrucci, 2016). Among the

“oldest old,” frailty may be accompanied with sarcopenia, which is the progressive decline of skeletal muscle mass, strength, and function associated with chronic inflammation and other conditions (Budui et al., 2015). Immunosenescence and systemic inflammaging from the aging process increase the risk for sarcopenia (Baylis et al., 2013), the onset of which requires intensive health supports in managing it (Greenlund & Nair, 2003).

HEALTH RELATIONSHIP VULNERABILITIES OF OLDER ADULTS

An underlying health relationship vulnerability of older adults is from ageism, the ascription of social stigma by young and middle-aged people against older adults, placing them at risk for human rights abuses (Voss et al., 2018). Ageism also has the effect of treating older adults as somewhat diseased, burdensome, and repulsive. This serves to disempower older adults, denying the older adults the credit for their time-tested wisdom in managing their life situations (Nahmiash, 2004). Uncertainty in personal relationships increases with age, amplifying the subjective demands and prominence that older adults place on initiating and maintaining close relationships, as well as exposing older adults to risk for abuse and exploitation.

Older Adult Abuse

Older adult abuse refers to “acts carried out with the intention to cause physical pain or injury; psychological or verbal abuse, ... emotional pain or injury and sexual abuse financial exploitation, involving the misappropriation of an older person’s money or property; and neglect, or the failure of a designated caregiver to meet the needs of a dependent older person” (Lachs & Pillemer, 2015, p. 1974). Globally, an estimated 15.7% of older adults (or 141 million) have experienced abuse (Yon et al., 2017). Within this population of older adults with an abuse history, 6.8% have experienced psychological abuse, 4.2% financial abuse, 2.6% physical abuse, and 0.9% sexual abuse. About 9% of older adults aged 57 to 85 years reported that they have experienced verbal abuse and 3.5% reported financial abuse in the past year (Laumann et al., 2008). These prevalent types of older adult abuse tend to co-occur (Labrum, 2017; U.S. Government Accountability Office [GAO], 2011) and are especially pervasive among older adults with disability (Fang & Yan, 2018). Most older adults age with or into disability, predisposing them to multiple forms of abuse, depending on their life situations.

Older adult abuse is likely to occur among persons with chronic illness or disability, which impairs the person’s independence and judgment and, in turn, makes it easier for the care provider who intends to cause harm or injury to the older adult (Nerenberg, 2008). While the specific content of the actions of older adult abuse may vary by cultural setting, abusive actions are perpetrated knowingly or intentionally by a caregiver or other person in a position of trust or guardianship over a vulnerable senior-age person (Enguidanos et al., 2014). Abuse can take place in residential care facilities and may include restraint, nutritional deficiency, and overmedication (Glendenning, 1999). In the United States, older adults are protected by federal/state/district statutes, but abuse actions may need to be linked to another crime, such as assault, theft, or fraud. This is a complex issue, and legal differences occur across locations (U.S. GAO, 2011). At the same time, older adult abuse is often under the public awareness radar (Gorbien & Eisenstein, 2005), making it less likely that older adults will get the social justice that they deserve in order to live safely and in fulfilling ways (Fulmer, 2003). For instance, they are likely to be left behind in catastrophic event evacuations, even while having physical mobility and transportation limitations (Cloyd & Dyer, 2010; Dostal, 2015). Older adult abuse in residential care facilities is seriously underreported (Gibbs & Mosqueda, 2004; Phillips et al., 2013).

Some older adults may present with self-neglect, defined by poor self-management; this then impairs the elder’s own health and safety, and has a negative impact on the person’s ability to take care of their own hygiene, nutritional needs, shelter, and/or medical care (National Center on Elder Abuse [NCEA], n.d.). Self-neglect is not a form of older adult abuse. However, what may seem like a case of self-neglect could be the result of ongoing abuse by

carers or other persons involved with the older adult's life situation. Examples include cases in which carers are negligent of hygiene, nutritional, and medical care needs of the older adults they have committed to assist (Glendenning, 1999) or acts of financial fraud on an older adult, risking their well-being (Smith, 2000). A vulnerable older adult may respond with self-neglect, believing that they are unable to extract themselves from an abusive relationship with a carer or other person (Enguidanos et al., 2014; Naik et al., 2008). For example, an older adult might endure maltreatment, fearing to be socially rejected or ostracized (Enguidanos et al., 2014). Self-neglect also might result from the challenges of self-management, in terms of aging process conditions (as with cognitive impairment and depression) that take away erstwhile abilities in the absence of alternative mitigation plans (Burnett et al., 2014; Pavlou & Lachs, 2006).

Social Vulnerabilities

Global trends suggest that the older age population will soon outgrow the number of people available to provide the supports needed (WHO & NIA, 2019), and increasingly, older adults will need cost-effective technology supports to manage their health needs (Hall et al., 2012). Social vulnerabilities of older adults include a foreboding sense of uncertainty about personal relationships that once were taken for granted. On the one hand, older adults may experience social vulnerability from the loss of family or due to a partner or carer relocating to another place or passing away. On the other hand, they may experience social strain from conflictual social interactions with family or with the partner or carer with whom they live, thus harming their psychological well-being (Ten-Bruggencate et al., 2018; Tough et al., 2017). The latter issue may be even more pervasive among older adults who are cognizant of their diminishing social network resources (Wheaton, 1985). The fact that older adults seek to regulate their relationships by investing in closer rather than more distal relationships makes them particularly vulnerable to risks for unwanted social isolation, which would harm their physical and mental health (Tomini et al., 2016). In addition, the rise of "elder orphans," those older adults who live in the community without family, carers, or surrogates, is receiving greater attention from mental health professionals, due to the higher potential for elder orphans to experience a sense of isolation, depression, and anxiety (e.g., Roofeh et al., 2020).

A majority of older adults is aging with or into disabilities (see previous section), for which they would need supports. Activities of daily living (ADLs) include both basic (bADL) and instrumental (IADL) functions. bADLs involve primarily personal care actions such as bathing, dressing, feeding, toileting, continence, and transfers, while IADLs involve participation in life situations like shopping, recreation and leisure, traveling, managing finances, and use of communication tools (WHO, 2001). With the aging process, declines in physical and cognitive function are associated with declines in the performance of ADLs, often requiring the help of carers and/or other clinicians.

Decision-Making in Older Adults

Aging-related declines begin to affect the efficiency by which older adults make deliberative or sequential staged decisions over extended time or activity frames. Rather, older adults would elect a shorter decision period and settle for a decision that carries emotional appeal. This would add to their vulnerability in high stakes healthcare decisions that require complex consideration of many options.

Most decisions that people make are tagged with some degree of affect and are comprised of positive and negative markers, colored by level of experience, real or imaginary (Slovic et al., 2007). Affect acts as a prism for action or effort investment choices, predisposing some pieces of information over other competing data points. It also serves to conserve decision-making energy by simplifying harder choices for intuitively appealing ones, substituting for what sometimes may be more relevant information (Kahneman, 2011). By definition, a decision results in a commitment to a categorical course of action, and the decisions people take or forgo have consequences for their health outcomes. People are known to adopt or forgo products and behaviors by their incentive values (Charness & Gneezy, 2009). However, decision science theory postulates that risk for personal loss would influence a decision more

decision science theory postulates that risk for personal loss would influence a decision more than opportunity for an equivalent gain or preserving current resources. Consequential real-world decisions about community living options are value based, as when “a subjective measure like utility is used to assign the relative desirability of each choice” (Gold & Shadlen, 2007, p. 560).

AGING PROCESS HEALTH RESOURCING

The aging process conditions, which older adults negotiate for successful aging, require comprehensive responses to mitigate the effects, including personal resourcing for self-managing their own health, social support by family, clinician support, and living arrangements. These resources optimize when working interactively, and their particular qualities would differ across individuals. Personal factors or “the particular background of an individual’s life and living, including features of the individual that are not part of a health condition or health states,” can affect functioning “positively or negatively” (Grotkamp et al., 2012; p. 48). These include individual differences such as gender, age, ethnicity, learning orientation, educational level, social background, past and current experience, overall behavior pattern, and so forth.

While older adults may perceive successful aging differently, they would seek to “select” and “optimize” present and prospective relationship capabilities for living well with an aging process condition (WHO & NIA, 2019). The hierarchical compensatory model (Barnett & Cantu, 2019; Pinquart & Sörensen, 2002) proposes that older adults would invest in health resources that they perceived to be accessible and efficient in meeting their needs, rather than in those requiring high effort demands to access or utilize. In making their choices about which health relationships to implement, older adults would consider their specific life situations. There is evidence to suggest that cues and prompts in the environment (as in life situations) make it likely that decisions regarding behavior will be made and implemented (Milkman et al., 2011). Box 12.1, which appears at the end of this section, illuminates these dynamics.

Technologies may help older adults aging with disability to participate and live independently in their communities. Use of computer and internet technologies by older adults (65+ years of age) is on the increase from 12% in 2002, to 67% in 2016 (Anderson & Perrin, 2017), a 42% increase in a decade and a half. By 2017, about 75% of U.S. households had a desktop or laptop, while 77% of adults in the United States had a handheld device such as a smartphone, and 51% had a computer tablet (U.S. Bureau of the Census, 2017). Within the senior population of adults, 82% of the younger older adults (<69 years) utilized internet-based resources, compared to 90% of the general adult population who regularly utilize online resources (Anderson & Perrin, 2017). Use of smart technology by older adults is employed more extensively by relatively young older adults (<65 years) who are more educated, have higher annual incomes, are healthier and more active, and are recognized members of their communities rather than a part of underrepresented segments of older adults (Anderson & Perrin, 2017; Berner et al., 2012; Cresci et al., 2010). This becomes particularly important with use adoption of smart technologies, in which there is a huge digital disparity divide that hinders older people with lower technology-use literacy from any cause, including intersectionalities in social disadvantage from lower socioeconomic status, disability, race, gender, disability, and rurality.

Personal Resourcing

With the aging process, gaps increasingly occur between what a person decides and what they actually do and can do (Glass et al., 1999). This has significant implications for self-management by older adults aging with or into disability. Older adults tend to invest in personal resourcing for health relationships that they perceive to be accessible to them, appropriate, and lower in intensity of resource-support demands, including decisional influences (Bruine de Bruin et al., 2012; Finucane et al., 2002).

Self-management is at the core of independent community living and participation, benefiting older adults in terms of autonomy, self-determination, and prioritization of personal

benefiting older adults in terms of autonomy, self-determination, and prioritization of personal values for preferred lifestyle (Mpofu, 2014; Ruchinskas, 2010). While older adults have aging-related declines in the efficiency of their decision-making, preferring to make deliberative or sequential-staged decisions over extended time or activity frames (Bruine de Bruin et al., 2012), they also show remarkable efficiency in motivated selectivity in decision-making, drawing upon their greater experience in managing their life situations (Peters et al., 2007). For this reason, older adults managing aging-related health trauma would make effective life situation decisions that are based on past experiences in providing appropriate guidance (Mata & Nunes, 2010) and about issues with which they had a higher affect investment (Slovic et al., 2007). There is evidence to suggest that affect may be resilient to the aging process, and affect-laden decisions would be a serviceable vehicle for life-situation decisions in older age (Peters et al., 2007).

Social Resourcing

In their social resourcing for health, older adults would prioritize spouses and children as their inner circle of social support, while other relatives and friends are in the middle circle (Huxhold et al., 2014). Other social partners would be in the outermost circle. Predictably, people in the inner circle, advantaged by the proximity in relationships, may have a stronger influence on life satisfaction than people in the outer circles (Antonucci, 1994). Family members are physically and psychologically closer to individuals than other people (e.g., friends, acquaintances) and typically provide relatively more social support than would other social relationships (O'Connor, 1995; Yeung & Fung, 2007). Thus, family and partners would be an important social referent group for older adults in their health management decisions.

People are more likely to adopt healthcare decisions that they perceive to be in line with how social referent group others (like family, partners, or significant others) would behave in a similar choice situation, perceiving them to be a source of accurate information about the appropriate behavior for the context (Holroyd-Leduc et al., 2016; Popejoy, 2005). This social influence occurs mostly through implicit communication by others in the person's social network regarding the desirability of health actions of the individual (Melnick & Li, 2018). The latter behavioral choice may be explained by the prosocial motives that people hold about their health decisions (Betsch et al., 2015), the implementation of which would serve to enhance their self-image with social referent group others, like family (Vietri et al., 2012). Moreover, older adults' decisional values may change over time, based on experience and interpretation of present and emerging social sources of information, thus altering the implicit decision rules about a desired health goal state (Gold & Shadlen, 2007; Pinquart & Sörensen, 2002).

Clinician Resourcing

Older adults would rely on their clinician relationship for guidance on their health decision choices. The effect would occur through in-built situational supports for a behavior, saving the person the additional effort to decide and act on a behavior (Chapman et al., 2016; Rodrigues et al., 2015). For instance, the decision to opt out of a health support is more likely than the choice to opt in, so that clients with the choice to opt out for a flu-shot appointment were more likely to keep the appointment, compared to those with the option to schedule an appointment if they wished (Chapman et al., 2016). Even a question about when to carry out a health action (e.g., cancer screening; Rodrigues et al., 2015; taking a flu-shot: Milkman et al., 2011) increased the probability of a pro-health decision implementation as much as making the decision to adopt a pro-health decision as the default decision (Patel et al., 2014). This effect most likely occurs through solution need priming, as with older adults who, upon being asked to consider use adoption of a clinician, supported aging process support for their everyday living. However, once a decision magnitude value is reached, the tendency to adopt a present choice decision as the default becomes subjectively compelling, so that additional valuable information may pass for noise and not be considered.

Recommendation of a particular decision by healthcare clinicians also enhanced its chances of a pro-health decision implementation (Brewer et al., 2017), probably due to the

of a pro-health decision implementation (Brewer et al., 2017), probably due to the recommendation assuming a default decision status. Finally, a decision-maker's sense of self-control is enhanced through self-binding to a course of action with the use of a commitment device (Mochon et al., 2017; Schwartz et al., 2014). However, older adults would vary in their adherence to health maintenance, as prescribed by clinicians, based on their individual preferences (Jansen et al., 2016).

Use of Smart Technologies

The use of sensor-monitoring devices that measure and support daily functioning by older adults living independently is on the increase, enabling their aging in place, in the comfort of their homes, and with a sense of community safety. Those older adults with assisted living also increasingly use smart technologies to (self) monitor their daily living and community participation access (Bruce, 2012). These digital devices serve to support older adults' ADLs: bADLs, and iADLs. As mentioned earlier in this chapter, bADLs primarily involve personal care actions such as bathing, dressing, feeding, toileting, continence, and transfers, while iADLs involve participation in life situations like shopping, recreation and leisure, traveling, managing finances, and use of communication tools. With the aging process, declines in physical and cognitive function are associated with declines in the performance of ADLs, and the use of sensor surveillance technologies for tracking the older adult's functional status may be needed for successful aging in place or for quality-assisted living (Cornelis et al., 2017). Sensors can be wearable, allowing for ongoing monitoring of the older adult's physiological and accelerometric activity statuses, while nonwearable (environment attached) devices utilize interconnected devices with or without internet connectivity to support participation in life situations. Smart homes are those residences equipped with interconnected devices to allow information exchanges between or among end users, who may be older adults who live in a home, and others elsewhere who may be clinicians.

Box 12.1 illuminates many of the older adult-related resources that have been discussed throughout this chapter.

Mr. Kempton was a lifelong smoker and occasional drinker and this, in some respects, can affect overall health and susceptibility to certain health conditions. Being from the Baby Boomer generation (1946-1964), his birth cohort has experienced chronic conditions exacerbated by the environmental exposures of their time, such as unregulated pollution, use of materials with asbestos, and the lead paint that was in many old houses, thus predisposing them to lung disease with susceptibility from smoking. Smoking was trendy among the Baby Boomers, and unregulated for most of the period that Mr. Kempton was an adult, as the long-term dangers were not well recognized.

BOX 12.1

Health Relationships Resourcing Following Stroke in Older Age

Mr. Roger Kempton is a 67-year-old man who is a retired Transportation Security Administration officer. He is living with aging process-related stroke conditions characterized by a right middle cerebral artery territory cerebral infarct with residual left hemiparesis, left sensory loss, visual field deficits, dysphagia, and receptive aphasia. Mr. Kempton also experiences right shoulder pain. He has a history of smoking and occasional alcohol drinking.

From the stroke experience, Mr. Kempton has moderate loss of muscle power functions of right upper and lower limbs. He also has difficulties following simple two-step directives, and impaired spoken language comprehension. Mr. Kempton needs assistance with mobility and activities of daily living, including with walking, self-care, and acquisition of goods and services. He has stopped attending local senior person group activities.

Mr. Kempton lives alone in a split-level house in a rural area. The side access of the house has four stairs with a steep unpaved pathway. The house has two stairs at the front access and two stairs between the living area and kitchen, without any rails. In addition, the shower recess and toilet have no rails. The fact that he is living alone without family is a

major barrier to his well-being.

Personal resourcing. Mr. Kempton is eligible for aged care community services. An older adult age helper from a local community agency is providing personal activities like showering, house cleaning, and meal preparation. Mr. Kempton asked for his daughter, in an enduring guardianship process, to assist him; this was due to his impaired communication functions, and would save him undue burden self-managing his life situation following his stroke experience. He also expressed a preference to move in with his daughter, who has a disability-friendly single story house.

Social resourcing. Following his stroke experience, Mr. Kempton is provided with community transport to visit a local day center and for shopping, thus increasing social participation. He required a disability taxi or disability community transport.

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Clinician resourcing To resource Mr. Kempton for self-managing his physical functioning, he is taking physical therapy from his clinicians for muscle strengthening and balance and mobility training with an aid.

Assistive technology. The community agency also provided for an electronic home safety sensor for quick-help calls. Moreover, home modifications for his independent living included a ramp for wheelchair access and a walking frame to facilitate community access.

Successful aging is likely among those aging with the health support resources for it. Being a retired transportation officer, Mr. Kempton would have had decent financial resources, inclusive of retirement savings and health insurance coverage. However, his rural residence may have constrained access to critical care services that simply were not available in rural locations.

CONCLUSION

The older adult population will endure one or more of the aging process-related health conditions for which they need a broad spectrum of relationships and resources to manage. At the same time, older adults are at an elevated risk for abuse and exploration in their relationships with family and other caregivers, for which they would need resourcing to mitigate potential or experienced risk. Older adult abuse is often an invisible phenomenon. Those most at risk of abuse are the "oldest old" (aged over 85 years). They may be socially isolated, living with several aging process conditions and with diminishing physical, social, and financial resources. Caregivers of older adults need to anticipate the typical aging process conditions that older adults would live with to best cultivate and support health support relationships with the older adults. Health relationship partnerships with older adults are critical to preventing, stopping, and ameliorating risk for abuse on them, for which they would be faced with diminishing resources to counteract in the face of also managing aging process conditions.

The older adult population is diverse, not only regarding their demographics, but also related to the aging processes with which they live and for which they would seek supportive relationships. This chapter addressed the major aging processing for which older adults would require supportive health relationships across a broad range of interactions, from their own self-management to the support of family and significant others, along with that of clinicians. Caregivers of older adults such as their physicians, case managers, nurses, and social workers seek to assist older adults in achieving a health-related quality of life. These supports are optimized with relationship building and maintenance in which the older adults themselves are active participants. Treating older adults as mere passengers in their own life journeys would be tantamount to maltreatment and abuse.

By focusing specifically on the decisional needs of older adults in the health relationship resourcing that they would need, the risk of patronizing older adults and providing them with suboptimal or unwanted health support is minimized. While relationship resourcing of older adults may not be the panacea for age-related structural disadvantage inequity in health services, approaches that are based on an understanding of the major aging process health conditions would contribute to implementing interventions for their overall health and well-being. Use of smart technologies increasingly will play a major role in the health relationship self-management of older adults. Such technologies will make a difference to the extent that they provide options to address present and emerging health needs from the aging process.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Review the myths and realities of aging: www.apa.org/pi/aging/resources/guides/myth-reality.pdf

Join the listserv to www.nia.nih.gov/news/focus-aging-federal-partners-webinar-series

View this short video clip: *Life Is a Ball* (2012, Pilotfish Productions LLC, 4 minutes)
<https://vimeo.com/54294149> The short film won the Assisted Living Federation of America (ALFA) Film Competition on Ageism in 2012.

Visit this resource for life course resourcing for the older adult population: <https://acl.gov/about-acl/administration-aging>

Visit this resource for comprehensive information on a variety of topics on lived aging:
American Association of Retired Persons: www.aarp.org

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PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Review the myths and realities of aging: www.apa.org/pi/aging/resources/guides/myth-reality.pdf

Join the listserv to www.nia.nih.gov/news/focus-aging-federal-partners-webinar-series

View this short video clip: *Life Is a Ball* (2012, Pilotfish Productions LLC, 4 minutes)
<https://vimeo.com/54294149> The short film won the Assisted Living Federation of America (ALFA) Film Competition on Ageism in 2012.

Visit this resource for life course resourcing for the older adult population: <https://acl.gov/about-acl/administration-aging>

Visit this resource for comprehensive information on a variety of topics on lived aging:
American Association of Retired Persons: www.aarp.org

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CHAPTER OVERVIEW

This chapter focuses on conceptualizing addiction in relationship to the experience of trauma. It briefly covers some of the major theoretical orientations used to understand how addiction develops in individuals with diagnosable substance use disorders and co-occurring trauma. The chapter highlights the importance of social neuroscience and identifies stigma-related obstacles to recovery. The chapter concludes with discussions of treatment approaches and strategies as well as the counseling implications of co-occurring substance use and trauma disorders.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Define addiction;
2. Conceptualize addiction in relation to trauma;
3. Develop an understanding of the relevant neuroscience related to co-occurring substance abuse and trauma;
4. Appreciate the role of social health in biopsychosocial treatments; and
5. Identify pertinent treatment approaches and counseling strategies.

"Not why the addiction, but why the pain." – Gabor Mate

INTRODUCTION

Many have noted that addiction and trauma go hand in hand. Trauma counselors are likely to encounter clients frequently whose use of substances or compulsive behaviors is problematic. Understanding what addiction is and appreciating the heterogeneity of addictive disorder presentations, particularly with coincident trauma, is necessary for sound decision-making about when clients require additional services or a higher level of care. It ultimately is necessary to treat addiction and trauma in an integrated fashion, as failure to address one often sabotages attempts to treat the other.

Some studies report that up to 95% of clients with a substance use disorder (SUD) also report a history of trauma in one form or another, and posttraumatic stress disorder (PTSD) is one of the co-occurring disorders with the highest prevalence in clients undergoing substance use treatment (Brown et al., 1999). While estimates vary, most studies of co-occurring disorders report that at least 50% of people seeking treatment for an SUD meet the criteria for PTSD. Co-occurring PTSD and SUDs have problematic prognoses, as they tend to relapse more quickly and experience stronger cravings for drugs, alcohol, addictive foods, and compulsive behaviors compared to those without PTSD (Coffey et al., 2002).

This chapter introduces distinct yet complementary ways of conceptualizing addiction and its relationship to the experience of trauma. It offers an overview of principles and approaches to treating co-occurring trauma and addictive disorders, as well as important considerations regarding social supports and recovery groups as adjuncts to treatment. This is accomplished in the following major sections of the chapter: Defining Addiction: Substance Use and Related "Addictive" Disorders; Ways of Conceptualizing Addiction in Relation to Trauma; Social Neuroscience: The Missing Link Between Trauma and Addiction; Presentations of Trauma and Addiction; Sequential, Parallel, and Integrated Treatment of Addiction and Psychological Trauma; Treatment Approaches and Counseling Strategies; Counseling Implications; and the Conclusion.

DEFINING ADDICTION: SUBSTANCE USE AND RELATED "ADDICTIVE" DISORDERS

DISORDERS

The [American Society of Addiction Medicine \(2021\)](#) defines “addiction” as both a medical disease and as involving environmental interactions. Importantly, addiction as a construct is not the same thing as becoming physically dependent upon a substance and experiencing physical withdrawal symptoms. For some substances, such as alcohol, opioids, and sugar (among others), prolonged use requires more of the substance to produce the same effect (“tolerance”), and abrupt cessation of the substance will result in physical symptoms (“withdrawal”), which can be life-threatening for substances like alcohol and opioids. (Sugar withdrawal entails a much-attenuated version of these withdrawal syndromes without any risk of mortality, but sugar affects many of the same neurotransmitter systems in the same brain regions, which is why it has long been known to help ease withdrawal from drugs and alcohol.) Yet while physical withdrawal and dependence is one factor that is considered in diagnosing an SUD, it is not a sufficient cause, or even the primary biological mechanism driving compulsive substance use. Other more important changes occur in the brain. Such changes may lead to loss of control over use, a change in the capacity to feel pleasure and motivation with respect to anything other than the drug, and changes in inhibitory control and decision-making circuits that cause a person to be unable to stop seeking and using the substance despite profoundly negative consequences. These brain changes also readily occur in response to repeated exposure to drugs that do not have a physical withdrawal profile, such as cocaine. Not everyone who uses highly addictive drugs, such as crack cocaine or even heroin, becomes addicted—in fact, it is a minority who do. Substantial scientific research is devoted to understanding the complex interplay among biological, psychological, and social factors that render some individuals more vulnerable than others to becoming more readily or quickly addicted, relative to length or intensity of drug exposure.

In addition to SUDs, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; [DSM-5; American Psychiatric Association, 2013](#)) introduces the diagnostic category of “Substance-Related and Addictive Disorders” to refer to so-called “process addictions,” or compulsive behaviors that exhibit the same features of SUDs. These include factors such as loss of control over the behavior (i.e., doing more than intended or for longer than intended), continuing to engage in the behavior despite severe negative consequences and/or a desire to stop, needing more over time to get the same effect (tolerance), and even withdrawal symptoms. At the time of this writing, only gambling disorder has been officially specified in this category, but several other behaviors were considered, including shopping, internet gaming, pornography viewing, nonsuicidal self-mutilation (“cutting”), and food addiction ([Potenza, 2014](#)). The committees considered that there was insufficient evidence at the time to include these as diagnostic entities, but they identified the need for further research, and additions to the category of substance-related and addictive disorders have been anticipated over time. In a later section of this chapter, frameworks for conceptualizing addiction in relation to trauma are offered in order to guide the trauma counselor in addressing these other compulsive behaviors when they function analogously to substance use in clients’ lives.

A more colloquial way of conceptualizing addiction is also relevant to consider. As Dr. Gabor Maté observed in a recorded interview with this author, we live in a culture that breeds compulsive behavior as a means to soothe the prickly emotional edges of rugged individualism and shame-based self-reliance ([SeekHealing, 2020](#)). Popular cultural conceptions of addictions may encompass things like “bingeing Netflix” or obsessively consuming social media feeds focusing on niche interests, adult coloring books, and excessive indulgence in hobbies such as knitting or baking. This broad definition of addiction contains two elements related to compulsion: (a) a pattern of obsessive thinking about engaging in a behavior that elicits a feeling of being high or intoxicated or that reduces anxiety or hyperarousal and (b) feeling compelled to persist in that behavior despite negative consequences. Human beings have a tendency to turn compulsively to activities and behaviors that help us to self-soothe or emotionally self-regulate when we feel pain that overwhelms our resources for coping.

While these more normalized impulsive and/or compulsive behaviors often do not rise to the level of “real” addiction phenomena, they are useful to consider for a few reasons. First, they

...of some addiction phenomena, they are useful to consider for a few reasons. First, they reveal something essential about the human condition to which the clinician, family member, and individual with an SUD can relate alike: we all impulsively make decisions that do not serve us when we feel painfully uncomfortable or disconnected from others or our lives. We begin to see that the concept of harm reduction is relevant to all drug use *and* compulsive behavioral engagement, with human beings attempting to balance the harms of continuing to experience painful emotions with the harms caused by the means for relief. This understanding can help normalize addiction, in ways that reduce both stigma and self-stigma, which are significant obstacles to recovery. Second, these manifestations reveal addictive behaviors as existing on a spectrum of normal to pathological, depending primarily on the degree to which a behavior impairs one's functioning in life. Yet it follows from this that such impairment may be more related to the social consequences of the behavioral dependence (often related to its stigma or legality) than the actual pattern of its use; we might consider caffeine versus morphine as an example. A compulsive behavior that is less mind-altering—say, compulsive book-coloring, television-binging, or shopping—can nevertheless lead to loss of employment and relationships. If we consider that there is a spectrum of compulsive reward-seeking behaviors that humans use to escape feelings of dis-ease or pain, then we can shift our focus to intervening with the factors that contribute to such dis-ease, which may be biological, psychological, and/or *relational* in nature.

Considering how biological, psychological, and relational social factors interact in complex ways to generate the powerful human motivational drive for relief, we finally arrive at the other universal human experience: trauma. Whether “big T” or “little t” trauma, all humans experience stressors which outstrip our capacity for coping at one time or another. Elsewhere in this volume is extensive discussion about what influences resilience to and recovery from the enduring effects of such experiences. In this chapter, we consider some of the underlying reasons for why addictive disorders are so astoundingly prevalent in individuals with traumatic histories, which involves both social and neurobiological consequences of trauma-begotten shame and isolation. Approaching both the conception and treatment of trauma and addiction through this lens adds nuance to considerations of best practices for intervening and treating both categories of disorders, and especially their co-occurrence. Ultimately, this perspective elevates the importance not only of biological and psychological treatment, but also social-relational interventions, which, until recently, have received little attention, despite the nominally biopsychosocial model used widely in assessment and treatment.

WAYS OF CONCEPTUALIZING ADDICTION IN RELATION TO TRAUMA

The Disease Model

There are several ways to conceptualize addiction, and it benefits the trauma counselor to be aware of these. The most dominant is the disease model, which considers that SUDs and so-called “process addictions” or behavioral addictions are the product of abnormalities in brain circuitries responsible for reward, motivation, memory, and related functions. While it is recognized that abnormalities in these brain regions and circuits lead to characteristic biological, psychological, social, and spiritual manifestations, the disease model asserts that the primary mechanism of addiction is neurological.

Over the past few decades, a wealth of research has supported this view, which considers that while the initial consumption of the substance or performance of the behavior may have been voluntary, over time the exposure to the neuropharmacological consequences of these substances and behaviors changes the brain such that it becomes nearly impossible to stop using them. According to Volkow et al. (2016), three major neurobiological processes are implicated. First, reward circuits in the brain become desensitized, which interrupts the capacity to feel pleasure and dampens the motivation for participating in everyday activities. Second, there is an increase in stress reactivity and its coupling to conditioned responses, which increases the incidence of cravings for drugs and behaviors and elicits negative emotions when these cravings are not sated. Third, there is a weakened influence of the brain regions responsible for decision making, inhibitory control, and self-regulation—referred to collectively as executive function—which leads to repeated relapse to use of the substance or

collectively as executive function—which leads to repeated relapse to use of the substance or behavior (Volkow et al., 2016).

The disease model does not suppose that addiction, as a chronic, recurring illness, is simply biological in nature and expression. Proponents of the disease model such as Alan Leshner, former director of the National Institute of Drug Abuse, consider that in addition to biology, behavior and social context matter (Leshner, 1997). They consider that a complex interplay between environmental and biological (especially genetic) factors determines who may become addicted to a substance and who may not. Understanding these factors is important, because even with powerful drugs such as opioids, which create physical dependence and withdrawal in everyone, it is actually a minority of people who are exposed to such drugs and become addicted.

Trauma-Centric Explanations

Developmental trauma is one of the greatest risk factors for addiction, with extraordinarily high percentages of childhood trauma of various types found in studies of individuals experiencing addiction. The famous Adverse Childhood Experiences Study (ACES; Felitti et al., 1998) found that for every additional adverse childhood experience (ACE), the risk of early life substance abuse rose exponentially with each additional ACE experienced; if an individual had five or more ACEs, they had seven to ten times greater risk for substance abuse.

There are two complementary explanations for this relationship between trauma and addiction. The first is that trauma, by definition, generates stress that overwhelms an individual's capacity to cope. People who use drugs often self-medicate in order to cope with the psychic and somatic consequences of trauma such as emotional dysregulation (both numbness and overwhelming pain), flashbacks, and shame. Developmental trauma is particularly associated with addiction, because it interferes with the development of brain systems responsible for stress responses, memory, motivation, impulse control, and behavioral "autopilot." This results in an inability to control the impulse to use a substance under stressful circumstances—and unfortunately, such brains are predisposed to perceive everyday occurrences as more stressful (Maté, 2010, p. 203) (Box 13.1).

BOX 13.1

A Note About Food Addiction

Of the potential "substance-related and addictive disorders," food addiction merits special attention for two reasons. First, the accumulating evidence makes it likely to become one of the next "behavioral addictions" to join gambling disorder as an explicit diagnosis. Second, the putative category of food addiction is highly relevant to trauma counseling because eating disorders, and especially binge-eating, are so prevalent in individuals with developmental and especially sexual trauma (Madowitz et al., 2015). Particularly for individuals who experienced childhood sexual abuse or rape, morbid obesity affords a feeling of safety and "sexual invisibility" by eliminating sexual attraction as a potential threat source. For many traumatized individuals, highly rewarding food use and binge-eating also provide a means to "ground" into one's body, in much the same way as has been proposed for "cutting" behaviors (van der Kolk, 2014). Alternatively, some behaviors may enable dissociation from the body, as with food restriction or the innate chemical consequences of purging. In this way, food and compulsive food behaviors are used as "drugs" to self-soothe and/or escape from an uncomfortably dysphoric experience, which traumatized individuals may perpetually feel, particularly when under stress.

Evidence for considering food addiction within the neurobiological umbrella of other addictions is steadily accumulating. Sugar and highly concentrated saturated fat have been shown to activate the endogenous opioid system in the same way as alcohol and painkillers (Colantuoni et al., 2002). Excessive exercise and induced vomiting also cause a rush of endogenous opioid release, which may lead, over time, to both tolerance to and withdrawal from purging behaviors in bulimia nervosa, leading some to suggest that such "behavioral

from purging behaviors in bulimia nervosa, leading some to suggest that such "behavioral addictions" are simply endogenous opioid addictions (Milkman & Sunderwirth, 2009). Similarly, the release of stress hormones, adrenaline, and norepinephrine with fasting may render anorexia an endogenous stimulant addiction in some individuals, with accompanying cravings for food restriction, and withdrawal symptoms when eating regularly.

It remains controversial whether certain ingredients such as sugars, high concentrations of saturated fat, and flour may have intrinsically addictive properties and whether food addiction is a construct that warrants consideration alongside (or apart from) eating disorders. However, its proponents note that similar neurobiological features have been reported for gambling, substance use (including tobacco), and binge-eating disorder (Potenza, 2014). There are some who think that food addiction is simply an extreme form or advanced state of progression of the named eating disorders. Others have hypothesized that multiple cases of each recognized eating disorder may meet a common set of criteria but actually exist on one of two different spectrums, an obsessive-compulsive/anxiety spectrum or an addiction spectrum (with the latter more frequently encompassing bulimia nervosa and binge-eating disorder than anorexia nervosa and orthorexia, but not necessarily to their exclusion). The difference between locating an eating disorder construct on one or the other spectrum may have to do with the way that some brains and bodies of individuals with eating disorders react abnormally to specific food ingredients, much like the phenomenon that occurs when people meeting diagnostic criteria for alcohol use disorder take the first drink.

While there are more women diagnosed with eating disorders than men, evidence suggests that the actual prevalence of lifetime eating disorders of women to men may be as high as 3 to 1 (Ziółkowska & Mroczkowska, 2020). Eating disorders in men are underdiagnosed, due to stigma and a lack of recognition, and may be diagnosed more frequently in nonheterosexual men due to stereotypes. Eating disorders may present differently with men, associated with a preoccupation with muscularity instead of thinness, and while many men with bulimia nervosa also purge through vomiting, purging behavior as a compulsive exercise may go unrecognized by clinicians. Eating disorders and food addiction should be screened for, particularly in men with histories of childhood trauma and substance abuse disorders. In one study, men with opioid use disorders (OUDs) have been found to be three times as likely to have food addiction or a binge-type eating disorder compared to control men (Canan et al., 2017). This connection to OUDs is unsurprising, when one considers that Naloxone, the opioid blocker that reverses overdose, was shown to reduce consumption of sweet high-fat foods in both obese and lean female binge eaters (Drewnowski et al., 1995). The National Comorbidity Survey-Replication found that a lifetime diagnosis of SUDs is associated with as much as a threefold risk of anorexia nervosa, an eightfold risk of bulimia nervosa, and a fivefold risk of binge-eating disorder, although these factors varied somewhat by the substance of abuse (Hudson et al., 2007).

Just as trauma is associated with an elevated risk for SUDs, the same is true for eating disorders and food addiction. For both men and women, sexual and physical abuse are associated with significantly higher rates of eating disorders, with emotional abuse more tied to eating disorders in women and physical neglect more tied to eating disorders in men. It also is common for individuals with traumatic histories to become cross-addicted in recovery and to substitute food for drug and alcohol use, and vice versa (Afifi et al., 2017). This is important for the trauma counselor to be aware of, particularly if a newly alcohol- or drug-abstinent client starts gaining weight rapidly. Later in the chapter, resources for individuals manifesting behaviors with food that resemble alcohol use disorders are suggested. As with all addictions, it is necessary to integrate trauma treatment with addiction treatment to avoid treatment sabotage by forcing abstinence without adequate trauma support, thereby leaving individuals without their only defensive coping mechanism for the effects of trauma.

Systems and Spectrums

Addiction is not a monolithic entity. While the diagnostic criteria for SUDs may be met, the subjective phenomena and use patterns may vary widely among individuals. Some people have patterns of prolonged binges punctuating long stretches of abstinence; some people become obsessively preoccupied with using a substance after the very first exposure, while others find their experience of a particular substance changed after a particular life event, triggering an escalation in use and eventual loss of control. Phenomenological examinations of addiction patterns reveal different subjective experiences of the same diagnosed entity. For example, many people who are self-medicating with alcohol may begin drinking addictively after exposure to a traumatic event to cope with posttraumatic symptoms, and may become physically dependent—clearly qualifying for an SUD. Yet a subset of these people may not be a true instance of the “alcoholism” phenomenon as it was described by the first 100 “recovered alcoholics” of [Alcoholics Anonymous \(1939\)](#) in their eponymous book. That book’s understanding reflected the then-prevailing medical perspective that alcoholism involved a physical “allergy” to alcohol. This “allergy” manifests as uncontrolled drinking after a single drink. The other qualifier was an experience of “mental blank spots” occurring at varying frequencies that prevented the individual, in the moment, from having any mental defense against that first drink (such as sufficient recall of a painful memory of previous experience). However, some individuals who have experienced severe trauma may drink to oblivion, not because of a physically mediated inability to stop drinking induced by the first drink, but because they are always intentionally seeking oblivion. (Of course, these conditions are not mutually exclusive, and individuals may be aware of only one while both may be operative.)

Typically, in individuals who qualify for an alcohol use disorder (AUD) diagnosis, the prolonged effect of alcohol on the brain alters brain circuits permanently, and the inability to drink moderately becomes permanently hard-wired, like the development of a severe allergy to a previously safe substance. However, a subset of people exists who may present with an identical pattern of drinking and consequences as others with an AUD. Some of these people find that, once they adequately have treated their trauma, they are again able to drink moderately. Many such people experience a deterioration of overall mental health, after resuming substance use, or else they may manifest cross-addictions, such as with food. This is *not* the norm, and it counters the prevailing wisdom of “once an alcoholic, always an alcoholic.” Because it is exceedingly rare that such experiments have positive outcomes for clients (and many are lethally disastrous), it is not considered ethical to allow for the possibility that a person might drink again safely one day. However, the existence of such people who, after trauma treatment, no longer feel compulsively driven to drink excessively bespeaks the actual heterogeneity of the phenomena which may all check the same set of diagnostic boxes. They demonstrate that, from a phenomenological standpoint, not everyone who drinks according to the same pattern has the same physical reaction to alcohol.

The concept that the same constellation of symptoms can arise from different combinations of physical manifestations is known as the *spectrum model*. *Spectrum disorders* are those disorders associated with a common larger set of symptoms that may present in different combinations and to different degrees in different individuals. SUDs not only occur on a spectrum from mild to severe (from a diagnostic standpoint, depending on how many of the listed symptoms are present), but they also occur on a spectrum of different patterns, such as an intermittent binge pattern, compared to a daily use pattern with physical dependence. The diagnostic concept of *spectrum* also connotes addictive phenomena that exist on a spectrum from normal (i.e., drinking more than intended occasionally) to pathological (i.e., drinking to blackout every time despite consistent intentions to have only one drink). Often, the boundary between normal and pathological is arbitrary, or determined by the consequences or degree of functional impairment. The spectrum model of neuropsychiatric disorders also is used to account for diagnoses that tend to co-occur, such as attention deficit disorder and depression, or Tourette syndrome, obsessive-compulsive disorder, and anxiety. The reason why these symptoms and diagnoses manifest in clusters is because each symptom or disorder may involve brain circuits that are critically implicated in other symptoms or disorders as well. If a

involve brain circuits that are critically implicated in other symptoms or disorders as well. If a particular brain circuit functions abnormally in a given way, either or both disorders may result, depending on the combination of other brain abnormalities that also are present (Wurzman, in press).

When we look at the brain as a set of circuits that sometimes share brain regions, like transfer stations of different colored subway lines, we begin to see that the brain is not a collection of brain regions but of functional brain systems that share brain regions. A systems understanding of the brain and a spectrum understanding of diagnoses are implicitly tied to one another, because spectrums of symptoms can be explained by systems that share "hubs" for brain activity involved in several functions. If something affects a hub, it will have downstream effects on multiple systems in characteristic ways. If something affects a set of hubs, it starts to limit the range of brain states that the set of symptoms can create. As a result, some brain states may start appearing more often than others, and these may be clustered according to which brain hubs have been affected. This tendency for the brain to occupy certain states more than others is what manifests as chronic inattention, depression, or anxiety—among many other possibilities.

Why is a systems understanding of the brain and the spectrum disorder model relevant to understanding trauma and addiction as co-occurring disorders? There are a few reasons. First, it follows from these understandings that something like trauma, which presents a functional insult to certain brain systems, can, over time, cause a spectrum of other symptoms to emerge by changing the function of key "hubs" for brain activity responsible for operations such as behavioral inhibition or emotional reactivity. In other words, the experience of trauma or experiences that may commonly follow trauma, such as perceived social isolation, may alter the activity of brain systems that *also* play a role in addiction. (By this logic, one might argue that trauma itself could be thought of as a spectrum disorder.) Second, it gives us a neurobiological understanding of the biopsychosocial model that clinicians commonly use for assessment and/or treatment. The biopsychosocial model considers that addiction results from a complex interplay among biological, psychological, and social factors. A systems understanding of the brain can help to explain how social factors could set the conditions for neurobiological abnormalities to emerge, or how cognitive behavioral therapy can lead to neurochemical shifts toward health, as a result of practicing less distorted thought patterns. Third, and perhaps most important, it suggests that biological, psychological, or social factors left *unaddressed* during treatment can act like dead weight to the system's *status quo*, preventing the individual's brain from shifting patterns among sets of brain-state patterns frequently experienced to patterned sets of brain-states that are more conducive to recovery and behavioral change (Wurzman, in press).

Social Neuroscience Implications for the Biopsychosocial Model in Addiction

As mentioned, the biopsychosocial model considers that addiction presentation is influenced by a complex interplay among biological, psychological, and social factors. Herein may lie a key clue as to why addiction has been so challenging to treat. Treatment systems often give lip service adherence to the biopsychosocial model for addiction, but in action, they often fail to appreciate some of the most critical implications of the model. Most important is the concept that if biological, psychological, and social factors have a complex interaction, then an intervention or stressor that influences any one of these factors will therefore have detectable effects in the other two domains. Each has the power to influence the presentation of any given SUD, but none can be considered in isolation of the others. For example, prolonged exposure to certain drugs such as opioids, alcohol, or methamphetamine changes the neurobiological substrate on which these drugs act. The neural microcircuitry that underlies the drug's effects as well as the neural circuits involved in volition, cognitive control, and impulse inhibition all become modified by exposure to the substance over time, such that it is no longer possible for an individual consciously to override an urge or impulse to use, despite a strong desire to do so. However, to reduce this to a mere biological phenomenon misses the essential point that factors other than drugs (or even comorbid diagnoses) can induce plasticity and "tune" the settings of these circuits (Wurzman, in press).

diagnoses) can induce plasticity and “tune” the settings of these circuits (Wurzman, in press).

One such variable capable of “tuning” the brain’s reward circuitry is social connection. Recent neuroscientific advances have demonstrated that social reward systems overlap with reward and motivational circuits associated with addictive drug effects. Social exclusion activates networks involved in pain perception, including the anterior insula activity, which also is seen to correlate with subjective cravings for addictive drugs in humans (Garavan, 2010). This is just one example of how functional neuroanatomy supports the biopsychosocial model, with relational social variables influencing the sensitivity of neural circuits that underlie addictive behaviors. It also highlights another consideration for proponents of the biopsychosocial model: the need to consider social factors as relational, instead of merely “social determinants of health” (e.g., housing near drug trafficking, active addiction in family members, socioeconomic stress) (Hunter-Reel et al., 2009). The biopsychosocial model most often makes reference to these nonrelational social factors as targets for intervention in treatment. While that is certainly a wise course of action, emerging neuroscience linking human disconnection and social deprivation with increased addictive and compulsive behaviors, coupled with evidence that social reward and addictive reward circuits overlap, suggests that relational dimensions of social factors, such as meaningful interpersonal connections, may be an even more important target for intervention (Heilig et al., 2016).

Currently, we have excellent interventions for biological factors in addiction: we have opioid agonist therapies for treating OUDs; we have medications for treating comorbid psychiatric and medical diagnoses; and we can intervene to improve functions like sleep and nutrition. There is a strong evidence base for practice in the psychological domain as well, including the following interventions (detailed in Chapter 27, “Trauma, Crisis, and Disaster Interventions: Integrative Approaches to Therapy” and Chapter 28, “Selected Strategies and Techniques for Counseling Survivors of Trauma”): cognitive and dialectical behavioral therapies to address cognitive distortions and emotional dysregulation; motivational interviewing to help clients move through the stages of change; relapse prevention training to teach clients constructive ways to cope with triggers and cravings; narrative therapy for social empowerment; Eye Movement Desensitization and Reprocessing (EMDR) therapy; and somatic therapies for treating trauma. Compared with these mental health treatments, existing social interventions are of a categorically different order. Presently, they tend to be limited to arranging for access to safe, sober housing; vocational rehabilitation; and perhaps a suggestion to find a volunteer position “to do service.” Unlike mental health therapies, these do not aim to modify an individual’s internal experience directly. The closer equivalent to mental health treatments would be interventions that support an individual to experience being vulnerable yet safe in relationship with others. Professionals are increasingly recognizing the need to support clients with social skills training and, even more importantly, safe contexts in which to practice experiencing healthy relationships and being a part of a community—and new programs are emerging to meet this need. Without the means to meet the relational needs of clients entering recovery, neurobiological and psychological interventions frequently are stymied by difficulties in shifting brain-state patterns, due to the gravity of neurochemical consequences of social disconnection. Social health interventions, if they lead to experiences of authentic human connection, have the potential to affect, directly, brain circuitry that is hijacked by addictive drug use, and therefore can act in synergy with the bio- and psychological interventions seeking to install new neural and behavioral patterns (Wurzman, in press). While these interventions are new and still experimental, as the field of social health is emerging, successful pilot programs and a strong theoretical rationale bodes well for their ultimate validation. One such program, SeekHealing, is featured in Box 13.2.

BOX 13.2

From the Field: SeekHealing: A Community-Sourced Social Health Intervention for Trauma and Addiction

Jennifer Nicolaisen, Co-Founder and Executive Director, SeekHealing, Asheville, NC

SeekHealing began when the founder’s close friend survived an opioid overdose and partnered with the founder to begin a holistic healing journey. As part of this process, the

partnered with the founder to begin a holistic healing journey. As part of this process, the two discovered the role of meaningful social connection and community belonging as critical elements in addiction recovery. Jennifer teamed up with a social cognitive neuroscientist and neuroethicist, Dr. Wurzman, and together they began to view the low recovery rates and the opioid overdose epidemic—indeed, all of the so-called “deaths of despair”—as symptoms of a broader epidemic of loneliness. The co-founders created SeekHealing to provide intentional experiences of human connection and to help individuals in communities acquire skills to socialize in healthy ways. The model is designed to serve alongside medical mental health treatment services.

Launched in 2017 in Asheville, NC, the Pilot program initially focused on serving individuals facing an addiction crisis or at risk for overdose. However, it soon became apparent that other participants who did not have a lived experience of bonding to a substance but rather experienced acutely painful disconnection associated with past trauma, recovery from other mental health conditions, or chronic health conditions were also benefiting from SeekHealing’s programming. This created a spreading awareness of the need to address *social health* as a construct distinct from social determinants of health or mental health in all of these groups.

As a social health provider, SeekHealing curates and delivers the relational tools, experiential offerings, and community-driven resources that support a stable social climate and

reduce the isolating tendencies that drive negative mental health well-being, such as substance abuse and depression. In creating (and iterating) a program where connection has been authentic, deep, and safe, SeekHealing discovered several key elements that are essential as core values for social health interventions. These include mutuality, nonhierarchy, nonjudgment, curiosity, and restraint from “fixing” or giving advice (or obtaining prior consent if advice is offered).

SeekHealing provides participants with a laboratory for focusing on their social health, while complementing the outcome-oriented elements of their other recovery systems. Centered around Community Calendar (CC), the project has regularly scheduled support meetings (in-person and online) where people can practice prosocial skills and healthy communication techniques, called Connection Practice. Other offerings include Art Therapy, Sound Meditation, Yoga, and Food From The Heart. All events are open to the public at no cost, based on a harm-reduction model, and guided by SeekHealing facilitators and volunteers. Facilitators are community members who receive 50+ hours of training and mentorship based on trauma-informed practices, transpersonal psychology, peer support, nonviolent communication, and attachment theory, developed with Dr. Gabor Mate as advisor. Participants—many of whom do not have lived experience with addiction—are led through relational exercises working to eliminate the stigma of trauma and addiction issues created by the division of staff and participants in a clinical setting. Connection Missions consist of technology-assisted, in-person outreach to activate social opportunities between volunteers and people who are isolated, struggling with active substance use cycles, or need emotional health support. These social opportunities include meal deliveries, check-in phone calls and texts, personal naloxone deliveries, herbal first aid, and pairing individuals to practice connection skills with each other. Connection Missions operate with mutuality: yesterday’s “volunteer” might become the one receiving help on a less-resourced day, and vice-versa.

Additional support services are provided to individuals at risk of drug overdoses or other acute deaths of despair through the Extra Care Program, which in addition to the offerings of the CC also provides a stipend for access to holistic healing services provided by “connection agents” in the community. Their offerings include yoga, chi gong, acupuncture, orthobionomy, reiki, traditional psychotherapy and EMDR, spiritual counseling, nutritional and herbal support, and more, all provided with a commitment to compassionate curiosity and nonjudgment. These participants also receive more proactive outreach and meet regularly with a program coordinator, to structure and guide their engagement and to be matched with higher levels of community support when necessary. Services within the program are never contingent on abstinence. Because the program is not limited to people in recovery from an SUD and the concept of harm reduction is normalized, SeekHealing serves as a bridge to help those in early recovery reintegrate into the broader community without the experience of stigma.

SeekHealing believes that there is no mental health without social health. More information can be found at <https://seekhealing.org/>

The COVID-19 pandemic in 2020 and 2021 made for an unfortunate “natural” experiment of what happens when we increase social disconnection and relational deprivation. Many people’s patterns of alcohol and drug use escalated sharply during the period of enforced physical distancing, leading to a loss of control and, in many cases, the first episode of substance use or disorder and treatment. Opioid overdoses, already epidemic, skyrocketed even higher. People who initially engaged in “stress baking” were qualifying for binge eating disorders by the end of the year. On the other hand, where it was available, providing for the relational needs of individuals amplified healing and recovery from the effects of social isolation exacerbated by COVID-19. While social health interventions are not a panacea, nor do they replace the need for biological and psychological interventions, they increasingly are being recognized as an essential complement to empower existing treatments to have lasting success in individuals.

Trauma, Shame, and Social Disconnection

Trauma, whether experienced during development or adulthood, is a powerful factor leading to social disconnection. Traumatic experiences often profoundly impair one's embodiment, in the sense that one may lose the ability to connect with one's inner experience, which is essential for being able to connect meaningfully with other individuals. Without the capacity to access a shared experience, relationships may become superficial and unsatisfying at best, and fearfully threatening at worst. Big attachment traumas such as abuse from a caregiver or sudden abandonment by a trusted partner, but also small attachment traumas such as ordinary day-to-day emotional wounds, can make connection feel scary and threatening. The common thread between traumas of widely varying magnitudes is the shame and feeling of "not enough" that emerges. Shame is a powerful emotion that promotes isolation and disconnection. This emotion is particularly deadly for clients who are seeking recovery from an SUD, because the trauma and its resulting shame often prevent individuals from accessing tools that could lead to connection with others. In 12-step programs, this manifests as the dreaded "10,000 pound phone phenomenon" where sponsees find it nearly impossible to take their sponsor's suggestions to reach out to either newcomers or experienced members of the program. This makes it impossible to "work the solution" that these programs offer, and the ultimate result is often a return to substance use.

The need to treat the trauma, in order to enable someone to tolerate abstinence (or the actions required to maintain that state), is discussed later in this chapter. It is important to note here, however, that the biggest consequences of trauma manifest relationally. Our trauma histories emerge in social contexts and deeply shape our social experience. The ways in which we have framed the disease model of addiction, historically, have been relatively inattentive to relational social factors. It is therefore unsurprising that, until recently, there has been a corresponding underemphasis on the role of trauma as a causal mechanism of addiction, relative to biological factors such as genetics and the lasting physical effects of drug use on the brain. Given the incredibly high rates of PTSD and SUD co-occurrence, and the nearly ubiquitous experience of some form of trauma in people diagnosed with SUDs, we need more research to understand better how social health has an impact on both pathology and recovery in addiction and trauma. Such research may clarify and confirm the consequence of neglecting social health in addiction and trauma treatment, respectively. It also may provide novel insights into barriers to recovery in present systems. If brain dynamics influencing behavior exist on biopsychosocial spectrums, social health interventions may just unlock the key to a truly integrative treatment of co-occurring disorders.

PRESENTATIONS OF TRAUMA AND ADDICTION

The relationship among the psychological/emotional aftereffects of trauma, including depression, anxiety, panic, PTSD, eating disorders, and addiction, is complex. Like all co-occurring conditions, trauma-related disorders and addictions can present themselves in several ways. For example, the development of an addiction can be an adaptive strategy for managing the emotional and psychological responses to trauma, and addiction to substances can make people more vulnerable to trauma, including rape and other kinds of violence that can cause trauma complications like PTSD.

Although the research literature indicates a strong association between trauma complications and SUDs, clinicians should not make assumptions about causal relationships. [Najavits et al. \(2020\)](#) suggest that co-occurring conditions like PTSD and SUDs can precede each other, follow each other, contribute to the development or course of each other, or arise independently of one another. Regardless of how trauma-related conditions and addiction present themselves and in what order, both disorders must be addressed simultaneously in treatment ([Najavits et al., 2020](#)). Furthermore, treatment is less effective in split systems, where clients may be rejected from mental health facilities until abstinent, or conversely, rejected from substance use facilities until stabilized ([Najavits, 2006](#)).

SEQUENTIAL, PARALLEL, AND INTEGRATED TREATMENT OF ADDICTION AND PSYCHOLOGICAL TRAUMA

AND PSYCHOLOGICAL TRAUMA

Treatment for co-occurring trauma-related disorders and addiction can occur along three treatment trajectories: sequential, parallel, and integrated therapy. [Burke and Carruth \(2012, p. 214\)](#) described these trajectories, briefly, as follows:

- **Sequential treatment:** One disorder is defined as “primary” and is treated first, followed by treatment of the “secondary” disorder.
- **Parallel treatment:** Disorders are treated concurrently but in separate treatment systems or by separate clinicians, generally without much coordination between the two treatments.
- **Integrated therapy treatment:** Both disorders are treated concurrently by the same clinician or treatment system, with recognition of how each disorder impacts the recovery from the other and with a high degree of coordination within the treatment system.

Most clinicians would agree that the third option is the most efficacious; unfortunately, however, this often is not what happens in practice. First, the treatment system for substance use often does not interact with mental health treatment systems that typically address trauma-related disorders (and vice versa). Such lack of communication is not conducive for sequential treatment. Clinicians in addiction treatment settings focus on getting people sober first, assuming that the trauma symptoms may subside or can be dealt with later by a mental health clinician. Clinicians in mental health treatment settings focus on managing trauma-related symptoms first, assuming that the alcohol and drug use or other addictive behaviors may subside or can be treated later by substance abuse professionals or self-help recovery groups. When trauma is a significant factor in maintaining substance use, and integrated treatment is not available, clients often must have their trauma addressed prior to attempting complete abstinence—at least to the extent of being able to self-soothe and cultivate a sense of safety. Without some means to cope with intense and/or frightening feelings, many people are not able to tolerate abstinence long enough for substance abuse treatment to be effective. Clearly, this is an arena in which the mental health and the substance abuse sectors need to coordinate services in ways that best benefit clients.

TREATMENT APPROACHES AND COUNSELING STRATEGIES

There is no single treatment approach or strategy to address such a broad-based and complex issue as psychological trauma and co-occurring SUDs. [Najavits et al. \(2020, p. 545\)](#) argue in favor of a public health approach to treating PTSD/SUD comorbidity, in which the therapeutic options “meet a reasonable standard of evidence and also meet the standard of being feasible in real-world settings (a public health paradigm).” Counselors have to consider the unique needs of the client, the context in which services are provided, and counselors’ own levels of training and skill in treating these co-occurring conditions. In this section, I examine some overarching approaches and specific strategies for integrated treatment of SUDs and trauma.

Treating the Symptom Versus Treating the Problem

A basic dilemma in both addiction and trauma treatment concerns symptom management versus treating the underlying dynamic. The primary symptoms of SUDs are obsession, compulsion, and harm caused by drug use. The primary symptoms of trauma are interpersonal withdrawal, hypersensitivity, and intrusion. Treatment systems addressing trauma-related disorders and addiction generally favor short-term, symptom-management approaches. This approach deems treatment successful if symptoms subside. In effect, no symptom, no problem!

SUD treatment programs tend to put their personnel and financial resources into helping people get “clean and sober,” rather than focusing on the more costly strategy of helping people change a way of life. Most clinical resources go into the first 30 to 90 days of substance abuse recovery. The result is that many people are left without long-term assistance at a critical time in their recovery when they are most likely to have a resurgence of trauma-related symptoms and thus are prone to relapse back into alcohol/drug use or

of trauma-related symptoms and, thus, are prone to relapse back into alcohol/drug use or addictive behaviors. These people then end up becoming the "walking wounded"; perhaps they are not using drugs, but they may continue to live a limited life. Likewise, in trauma treatment, the bulk of clinical resources go into reducing symptoms of hyperarousal, interpersonal withdrawal, and intrusion (often through psychopharmacology). But this simply creates short-term relief for many clients who continue to experience the underlying symptoms of trauma: disturbed interpersonal relationships, low self-esteem, a lack of hope and optimism, diminished self-efficacy, and difficulty experiencing the joys of life. As discussed previously in this chapter, and again in the text that follows, social health interventions that focus on relational health and the experience of deep interpersonal and community connection can amplify the effects of both trauma and substance use treatment. This can happen by restoring a sense of meaning in life and by providing access to a nonprofessional support system, which many individuals have lost due to their substance use.

It should be noted that clients with both disorders can become willing coconspirators in ending treatment too quickly. For instance, when clients are no longer experiencing intrusive nightmares or have not had a drink in 30 days, they may be only too willing to declare themselves "better" and no longer in need of treatment. Few people voluntarily wish to explore their painful inner functioning and past to understand how these wounds manifest in their current lives and interfere with self-esteem, relationships, and a sense of belonging.

For some adult traumas, particularly "single-event" traumas such as a rape, an armed robbery, a near-death health crisis, or the death of a spouse, it may be appropriate to address only the trauma symptoms and not "delve deeper" unless the client signals that such exploration might be useful. They might signal the need to delve deeper, for instance, by suggesting that the single event activates other traumas in their history or by reports of long-disavowed affective states that emerge when ego defenses are down, such as upon awakening in the morning. When higher-functioning people go through a traumatic time, the risk of significant wounding at the level of self-functioning is lower than with a person who does not have very good coping skills. However, even for higher-functioning people, it might be wise to see if symptoms of a self-wound appear before probing. In a similar vein, some people can, with positive support from others (and sometimes strong sanctions against continuing the behavior), cease a destructive compulsive pattern such as alcohol or drug use, compulsive sexual behavior, shoplifting, or gambling and not need additional treatment. However, anecdotal evidence suggests that these clients are the exception, not the norm.

Many clients with SUDs can look—and are—remarkably improved after 30, 60, or 90 days of abstinence. However, a part of what is clinically relevant in this circumstance is that the psychological defense that individuals have employed—and continue to employ—to look "good enough" to self and others may be hiding enormous underlying pain. In some cases, the rebound from the physical effects of the substance or behavior causes a temporarily inflated sense of well-being known as the "pink cloud" phase of recovery. Stressful life events often trigger a precipitous "fall off of the pink cloud," and what appeared as a high level of functioning can deteriorate extremely rapidly into a return to substance use.

Not every client with co-occurring trauma-related and addiction disorders needs long-term treatment. Some clients can benefit from relatively short-term intensive treatment, followed by supportive counseling or self-help programs. However, it is critically important to be cognizant of the fact that many, and perhaps a majority, of this particular category of clients need more. Finally, these additional services have to be matched to the specific needs of the clients. No one treatment protocol effectively can address the wide range of treatment and recovery needs of people with such diverse presentations of trauma and addiction disorders.

Staging Treatment

It is helpful to think of both trauma and addiction treatment as occurring in stages. The symptoms presented in early treatment are not necessarily the symptoms that become evident later on. Likewise, treatment needs vary depending on the phase of treatment. Finally, the role of the clinician may differ significantly depending on where the client is in their recovery. This subsection focuses on early treatment, because this is the point at which the interaction of trauma symptoms and addiction symptoms are most likely to be prominent.

the interaction of trauma symptoms and addiction symptoms are most likely to be prominent. Once a client has stabilized in recovery, it is often more common for the client to be able to separate symptoms of one disorder from the other. Likewise, in more extended recovery, symptoms like low self-esteem, relational difficulties, lowered self-efficacy, repression of specific emotions, and overreactivity to environmental stressors often blend; it becomes more difficult, in these later stages, to describe a symptom as specific to trauma or to addictive illness.

In general, early treatment is focused on goals such as symptom management, reducing triggers and cues, stabilizing the psychosocial environment, learning about trauma and about addictive illness, developing a better understanding of recovery, and developing hope that life can be better. As clients master these tasks, other dynamics in a second stage of treatment may begin to be more prominent. The latter are marked by some of the following: being able or unable to manage success; continuing or not continuing relational patterns that are self-destructive or unfulfilling; and confronting problems that arose during the process of addiction, or have evolved as a result of trauma, such as bad decisions about jobs or careers, patterns of family relations that are limiting or retraumatizing, or decisions about the future of marriage or other important relationships. These are most often problems that predated treatment entry, but it is only after a period of stabilization that they emerge to the forefront. These dilemmas for the client require different treatment strategies and change the therapeutic stance of the clinician. In earlier treatment, the clinician might have been more directive, more focused on therapeutic boundaries, and more structured in the therapeutic endeavor, thus allowing the client to develop a dependent therapeutic relationship.

As treatment progresses, the clinician might elect to focus more on the client's affect, encouraging insight and supporting the client in making their own decisions; at this point, the therapist begins to appear less confrontational. In an even later stage of treatment, the clinician might take on more of an advisor role, walking alongside clients as they make their own decisions. A final stage of treatment involves the client's separation from the clinician, allowing the client to "let go" of a resource that has been a significant part of their lifeline for the duration of therapy. Being able to achieve their own separation healthily, in and of itself, can be a major therapeutic step for people who have experienced significant abandonment or attachment trauma.

Counseling Strategies in the Early Stages of Treatment

There are several specific counseling strategies that are useful in the early stages of treatment of trauma after-effects, SUDs, and process addictions. Perhaps the most important strategy is to create a safe working relationship, balancing the client's need for control and therapeutic relationship boundaries. While clients need clear boundaries to establish safety in the therapeutic relationship, when working with people with trauma-related disorders and addiction, the clinician also must recognize that the client needs to feel a sense of control in the relationship—a sense of control that was shattered during the trauma experience. Trauma has an impact on how people perceive the world, that is, their thoughts, judgments, intuitions, and their relationship to their emotions and physical experience. People sometimes shrink their world of experience in an effort to make it controllable, while simultaneously and paradoxically feeling out of control.

Addiction also can have an impact on how people perceive the world: their thoughts, judgments, intuition, and their relationship to their emotions and physical experience. Obsessive thinking and compulsive behaviors associated with addiction are actually coping strategies (or responses to trauma) and are employed by traumatized people to gain a sense of control; however, this paradoxically may increase their experience of being out of control. The person who suffers from trauma complications and addiction is dancing this dance of control in a vicious circle. The goal of the clinician is to dance with the client in a mutual process of following and leading, in order to enhance the client's sense of empowerment in the context of a safe relationship. Unfortunately, the rhythm of the dance is rendered "less than smooth" by some of the differences between "standard" trauma and SUD treatment. For example, in traditional SUD treatment programs, it is often a goal to get clients to "admit"

that they are alcoholics or addicts and to confront those who do not. For trauma survivors, the shame that is associated with feelings about the loss of control that is engendered by this "admission" may activate the shame of the trauma experience and become overwhelming, or the push to make an admission may feel like another violation of personal boundaries. In the Seeking Safety model of treating the co-occurring conditions of trauma after-effects and addiction, Najavits (2006, p. 245) states that "the heavily confrontational style of some SUD group therapies [should be] avoided to maintain the safety of a trauma-focused treatment. Accountability, but not harsh confrontation, is emphasized."

It is more useful in the context of SUD and trauma-focused treatment not to focus on confronting clients about making an identity declaration of addiction, but rather to use collaborative counseling strategies that facilitate agreement about which addictive behaviors the client is willing to change and how those changes can occur. One such collaborative method is motivational interviewing, which is a value-centered approach to helping people change health risk behaviors (Miller & Rollnick, 2013). Although the ultimate goal of addiction treatment is abstinence from substance use, harmful compulsive behaviors, and process addictions, this collaborative approach to counseling recognizes that stabilization and harm reduction are important intermediate goals. Such an approach enhances a mutually agreed upon agenda of behavior change between client and clinician. The client can regain a sense of control over their life and can manifest a sense of empowerment by retaining a measure of control over the treatment agenda.

Other counseling strategies, which are essential to the successful treatment of SUD and trauma, involve employing supportive psychotherapy to explore the relationship between trauma aftereffects like PTSD and SUDs, along with psychoeducational methods to address the roles that substance use and compulsive behaviors have in reducing the heightened anxiety, hyperarousal, and flashbacks that frequently occur when people stop using substances and/or engaging in compulsive behaviors. The key here is to educate people about the effects of trauma and how substance use and addictive behaviors are understandable responses to the trauma aftereffects. An implicit subtlety here is for clinicians to emphasize that harmful behaviors such as cutting, drinking to pass out, and compulsive overeating are not to be dismissed or excused but are to be understood in the context of the client's traumatic experience. Supportive psychotherapy and psychoeducation can help clients to understand that they have choices about the strategies they employ to cope with trauma. These approaches also reinforce that although substance use may provide temporary relief from some of the intensity of the trauma effects, in the long run, it leaves them feeling more out of control than in control.

Processing of trauma memories needs to be delayed until a client's SUD and compulsive behaviors are stabilized and they have established sufficient coping strategies to manage intense affect. Much of the clinical literature indicates that clients run the risk of increased substance use, or relapse back into substance use, after a period of abstinence, if specific trauma memories are processed prematurely in treatment. According to Najavits (2006, p. 244), "Opening up the 'Pandora's box' of trauma memories may destabilize clients when they are most in need of stabilization." Najavits further points out that clients "may not feel ready for trauma processing early in SUD recovery; others may want to talk about the past but may underestimate the intense emotions and new disturbing memories" (Najavits, 2006, p. 244).

Traumatic experiences can overwhelm people's sense of control, connection, and meaning; they then tend to engage in a defensive strategy of disconnection that serves to protect them, superficially, from further threat, whether actual or perceived (Herman, 1992). People with SUDs and process addictions also tend to become isolated and disconnected from meaningful relationships with family, friends, coworkers, and others. For a person suffering from addiction, the drug or the compulsive behavior becomes like a capricious lover, and the relationship to that love object takes precedence over all other relationships. Therefore, an essential counseling strategy—especially in the early stages of treatment and recovery, when clients give up or dramatically change their relationship to the drug or compulsive behavior and are feeling isolated, alone, anxious, and depressed—is to work collaboratively with clients to replace this unhealthy relationship with healthy social supports. Such supports historically

have included recovery support groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Overeaters Anonymous (OA), Women for Recovery, Self-Management And Recovery Training (SMART), and so forth, although newer models continue to emerge.

Engagement in social support networks helps clients to reestablish meaningful connection to others and to decrease isolation. A renewed sense of connection can help reduce the hyperarousal that people with trauma complications suffer, although this is true only if they feel safe. However, participation in these groups often presents difficult challenges to individuals with trauma histories, such as an expectation of making outreach phone calls. All 12-step groups are autonomous, and some meetings contain individuals with more hostile views of psychiatry, which can leave clients fearful to disclose or discuss the way that their experiences with trauma have affected their substance use. It is also important to understand that while fellowship and close, supportive relationships occur in 12-step groups, they are not the primary focus, nor are they guaranteed, simply by attending meetings. The fellowships, where members come to encounter one another and support each other in the program, are distinct from the actual *program* of recovery, which is the 12 steps. While a general improvement in relationships is a promise of working the 12 steps, not all groups provide similar degrees of social support to members, nor are recovery rates necessarily linked to such social support.

Newer, innovative organizations, such as SeekHealing, focus more explicitly on social support and relational health and have been designed to meet the human need for authentic, meaningful social connection. They tend to be more “pan-recovery” oriented, in that participants may be healing from addiction, trauma, other mental health conditions resulting from or exacerbated by social disconnection, or simply loneliness. Because not everyone in the groups has a diagnosis, and participation is drawn from a wide variety of individuals in the broader community, “little r” recovery groups such as SeekHealing provide a means for individuals to reconnect with the broader community, outside of the often-siloed communities of people with lived addiction experience. As evidence grows for the effectiveness for these interventions, meetings focused on social health may become a very valuable complement to participation in psychotherapy and other “capital R” recovery groups.

Recovery Support Groups as an Adjunct to Counseling

As noted earlier, recovery support groups can be an important adjunct to individual counseling for people with co-occurring conditions of SUDs and trauma-related conditions. Most recovery support groups are patterned after AA, which is based on the 12 steps of recovery. The 12 steps are principles for living that accomplish the following: emphasizing powerlessness over the substance or addictive behavior; making amends with people harmed as a result of destructive, addictive behavior; and developing a spiritual connection to self, others, and something greater than the self. Types of 12-step support groups that might be useful for people with co-occurring addiction and trauma-related conditions include AA, NA, Drug Addicts Anonymous (a newer fellowship in which qualification for membership overlaps with NA, but the Big Book and AA literature is used to guide the action of working the steps), Cocaine Anonymous (CA), Heroin Anonymous, (HA), OA, Gamblers Anonymous (GA), and Emotions Anonymous (EA), among others.

Another 12-step group, Adult Children of Alcoholics and Dysfunctional Families (ACA, or ACoA), is explicitly aimed at recovering from the effects of developmental trauma and adverse childhood experiences, which often occur (but not exclusively) in family systems with alcoholism or addiction. This program has a slightly different approach to the 12 steps, in that it focuses on re-parenting one's inner child as a part of the spiritual path to recovery and encourages a “blameless inventory” of not only oneself, but the whole family. However, clinicians are cautioned that abstinence from compulsive use of substances, food, or behaviors is required before ACA steps can be worked effectively. Some seasoned members of these fellowships recommend that individuals struggling with addictions first achieve stable sobriety before delving into this “deeper layer of the onion” of the work, as ACA meetings also may be triggering. Other recovery support groups that are not based on the 12-step model include Women for Sobriety, which incorporates a spiritual component, and SMART

model include Women for Sobriety, which incorporates a spiritual component, and SMART and Secular Organizations for Sobriety (SOS), which do not include spiritual components. Refuge Recovery and its offshoot, Recovery Dharma, which maintain a spiritual emphasis rooted in Buddhist principles of non-attachment, are increasingly popular alternatives to 12-step groups.

In addition to social support, recovery support groups and fellowships also provide cognitive reframing functions that are consistent with cognitive behavioral therapy (CBT), which have demonstrated efficacy in treating SUDs and PTSD. For example, AA slogans, which often are hung on banners in meeting locations, such as “one day at a time,” provide people with a kind of reminder to return to the present moment when their minds project into the future or get obsessively stuck in ruminating about the past.

The spiritual focus of many recovery support groups can be helpful to clients who have suffered the devastating effects of trauma by helping people reconnect to meaning in their lives. In addition, numerous studies have shown that alcohol or other drug abuse is associated with a lack of meaning in life, and those without an active religious or spiritual life are more likely to fill this void with alcohol or drugs (Laudet et al., 2006). Although the spiritual aspects of recovery support groups are not for everyone, it is important to explore this potential resource with clients in counseling.

Facilitating active involvement in recovery support groups is an important aspect of the counseling process with people who suffer from addictions and trauma complications. This counseling strategy involves exploring clients’ understanding of recovery support groups, dispelling myths and misunderstandings, educating clients about the benefits and potential risks of participation, helping clients resolve ambivalence about attendance, helping clients decide on and locate appropriate meetings, and monitoring clients’ reactions to meetings.

Many clients feel ambivalent and anxious about attending recovery support groups. Many feel ashamed about being identified as an “alcoholic” or “addict,” and others simply are uncomfortable in groups. Such clients may respond more favorably to meetings like those of SeekHealing that feature a participatory destigmatization model, in which all compulsive means of dissociating from difficult emotional experiences—up to and including binge-streaming television shows—are considered as harm reduction, and accordingly normalized. SeekHealing thereby deliberately obscures the distinction between an “addict” and “non-addict” in favor of experiencing a sense of authentic connection over universal human experiences. Still, in all recovery support groups, clients with histories of trauma may feel overstimulated by the environment and experience a reactivation of trauma memories. It is important to work collaboratively with clients in resolving their initial ambivalence about attendance at meetings and to develop a desensitization plan.

Peer support specialists, or “recovery coaches,” also can support clients by helping them to navigate between treatment systems and community support, including recovery meetings. They can assist in lowering the barriers, which some clients experience, to attending meetings, particularly if they also have subjective experience with trauma recovery in addition to addiction. Finding the right support group for each client is an important part of this collaborative counseling strategy. For example, women who have been sexually traumatized by men often find the predominantly male atmosphere of AA, NA, CA, and other recovery support groups to be anxiety provoking. Women’s groups of AA and/or Women for Sobriety meetings might be more acceptable for these clients. It is important for clinicians to respect clients’ trauma experiences and to encourage them to investigate acceptable meetings. Miller and Rollnick (2013) suggest that any plan, developed in collaboration with clients to help them change health-risk behaviors, needs to be accessible, acceptable, and appropriate for each individual.

It is possible for some individuals to find that the support group environment is inadvertently retraumatizing. Retraumatization can occur in various ways in self-help support groups. For instance, hearing other participants openly describe trauma events in their lives can open memories and disavowed affects for some individuals, particularly those new to the program. Individuals with weak interpersonal boundaries may misinterpret the interest and attention given to them by others and then feel rejected and abandoned. Some individuals can become prematurely involved in sexual relationships with other support group members

can become prematurely involved in sexual relationships with other support group members and unconsciously “reenact” their trauma experiences.

The role of the “sponsor” in 12-step self-help environments can be particularly therapeutic, but it also can be fraught. A sponsor is another member of the group with more experience in recovery, who acts as a mentor and coach for newly recovering individuals—ideally to guide them through the 12 steps. However, the intimacy of these relationships varies widely; sometimes sponsorship becomes a close and nurturing relationship beyond mere guidance with step work. It is not uncommon to hear an individual say, for example, “My sponsor in AA was like the father I never had.” Having someone in the role of a safe and nurturing parent figure, as a client moves through the recovery process, cannot be underestimated. However, styles of sponsorship vary widely, and, in some instances with sponsors who have not yet addressed their own relational issues, these relationships may become highly codependent, controlling, or even abusive.

Healthy sponsors help sponsees to work the steps and to get connected to a “higher power,” but do not recast themselves as anyone’s higher power, instead modeling and encouraging sponsees toward spiritual action to help them cope with life’s turbulent moments. However, as with parenting, people often sponsor the way they were sponsored, and varying means of influence may be normalized in such relationships. This is not necessarily unhealthy, but it is very important that clinicians monitor the client’s participation in self-help environments, supporting the person’s involvement, helping the individual to integrate their learning in different recovery environments, and being observant for signs of potential retraumatization. Being able to handle the potential retraumatization in a positive and productive way can be particularly therapeutic for individuals in early recovery, especially for those who have a limited repertoire of coping skills. Relationships in 12-step programs can be catalysts for growth, even when challenging.

Self-help programs offer the potential for powerful therapeutic growth through the process of identification, sharing, and belonging. This is particularly true for clients who have experienced abandonment trauma, thereby interfering with their ability to bond with others. Self-help programs can aid clients to experience intimate sharing in a safe environment and especially to have a sense of belonging; such programs can offer significant therapeutic gains that may not be available in individual counseling settings. Clients in self-help programs can proceed at their own pace, have the opportunity for meaningful feedback from others, and can learn to modulate their own sharing and involvement.

Spirituality in Trauma and Addiction Treatment

An additional counseling strategy, which can be employed at all stages of the treatment process, is to work collaboratively with clients to enhance hope and resilience through the exploration of their own understanding of spirituality. Unlike religion, spirituality does not refer to any particular dogma or set of beliefs. Rather, spirituality is primarily concerned with the personal search for meaning and a felt sense of connection with some ultimate or transcendent reality. A popular quote in 12-step recovery rooms is, “Religion is for people who are afraid of hell—spirituality is for people who have already been there.” Spirituality can enhance a person’s vitality and sense of interconnectedness with all existence (Grim & Grim, 2019), thus combating the pervasive sense of disconnection that both traumatized and addicted people chronically experience (Herman, 1992). Research has demonstrated that alcohol/drug use also is associated with a lack of meaning in life. Active spiritual involvement can reduce the risk of substance abuse, contribute to the formation of a resilient worldview, strengthen long-term recovery, increase coping skills and resilience to stress, enhance hope, and act as a protective factor in preventing alcohol and drug abuse (Burke, 2006).

Exploration of spirituality in counseling needs to be inclusive; it needs to honor the client’s own experience and to assist the client in understanding the broader meaning of personal trauma. For example, instead of getting caught in discussions about religious beliefs, which often can become impersonal debates, it is important to ask clients about their spiritual practices, such as walking in nature, praying, or meditating, which might be considered helpful during times of high anxiety or when there is a temptation to drink, use drugs, or engage in addictive behaviors. It also is important to explore spiritual experiences, values and

engage in addictive behaviors. It also is important to explore spiritual experiences, values and ethical principles, relationships to spiritual teachers, connection to sacred space, and how spiritual communities (whether a meditation group, church, AA group, and so on) have been or could be a resource to help people stay sober and reconnect with social supports (Burke, 2006). The exploration of spiritual community, in an inclusive and collaborative way, can support clients with SUD and trauma complications; it holds the potential for helping to find hope, rebounding from adversity, connecting with a greater meaning and purpose, and reconnecting with social supports that had been lost after the original trauma.

COUNSELING IMPLICATIONS

Due to the complexity of working with clients with co-occurring issues of psychological trauma and SUDs, along with the demands of high-stress treatment environments, clinicians are at risk. They are at risk for developing secondary trauma (signs of PTSD related to exposure to clients' trauma material), vicarious traumatization also known as compassion fatigue (a negative shift in worldview and self-identity), burnout (the general psychological stress of working with difficult clients), and intense countertransference reactions (these relevant clinical issues are discussed in Chapter 30, "Vicarious Traumatization"). To prevent and/or reduce these risks, it is essential for clinicians to develop comprehensive personal and professional self-care plans that include a relapse prevention plan for those who are themselves in recovery from SUDs or process addictions (the importance of self-care is detailed in Chapter 31).

Although personal responsibility is important, the clinical and research literature suggests that a team approach, whereby members of the treatment team or supervision group share in the responsibility of caring for complex and challenging clients, can prevent or mitigate the impact of secondary trauma as well as intense countertransference reactions by clinicians (Burke et al., 2006). The literature also suggests that treatment agencies can support clinicians in their efforts by adopting a trauma-informed approach that normalizes secondary trauma reactions and vicarious traumatization, validates and encourages clinician self-care, and creates an atmosphere of empowerment and respect for both the client and the counselor (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a, 2014b).

CONCLUSION

A complex relationship exists between psychological trauma and addictive disorders. Although not every clinician who works with people with these co-occurring conditions needs to be an