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Treating Traumatic Stress and Substance Misuse: A Guide to Integrative Practice.
By Denise Hien and Lisa Caren Litt.
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CHAPTER 2

The Need for Integrative Care

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In this chapter we present a rationale for integrative care for individuals living with both trauma-related and substance misuse conditions. We review clinical presentations and considerations related to traumatic stress, along with important diagnostic perspectives on PTSD and complex PTSD (CPTSD). Pathways between trauma and substance misuse that inform treatment decision making are also reviewed. We use Ms. A's and Mr. B's cases to highlight the ways that treatment framing from an integrated perspective is crucial to clinical care, as well as the ways that individual differences must be at the forefront of case conceptualization and treatment planning.

Perspectives on PTSD and CPTSD

Among individuals exposed to traumatic events, a significant number experience distress in the acute period posttrauma but before long see their symptoms resolve. Only about 20% develop PTSD. Others may develop mood or other anxiety disorders, without PTSD. The type and chronicity of trauma and age of exposure to traumatic events play a major role in terms of individual vulnerability, diagnosis, and prognosis. Interpersonal trauma, especially childhood maltreatment and abuse, poses a higher risk of developing PTSD and what we have come to identify as CPTSD and other mental health disorders than do accidents and natural disasters (Brewin et al., 2017). The earlier the onset and the longer the duration of trauma, the more likely individuals are to have more severe symptoms of PTSD, as well as other difficulties including substance misuse, depression, dissociation, somatic complaints, and difficulties managing anger and impulsive behavior.

Posttraumatic Stress Disorder

PTSD symptoms arise in response to exposure to trauma that overwhelms one's ability to cope. Hallmark posttraumatic stress symptoms have typically included reexperiencing aspects of the traumatic events, avoidance of reminders of the traumatic experiences, both internal and external, and hypervigilance and physiological hyperarousal. The *Diagnostic and Statistical Manual of Mental Disorders* (5th edition, text revision [DSM-5-TR]; American Psychiatric Association, 2022) has taken a broader view of PTSD by including the impact of the traumatic events on thoughts and emotions. Readers are referred to DSM-5-TR for specific diagnostic criteria that include identification of at least one traumatic life event and assessment of four clusters of associated symptoms. Trauma of the magnitude of life events defined by DSM-5-TR is not rare; approximately 70% of adults worldwide experience at least one such event within their lifetime (Kessler et al., 2017).

Complex Posttraumatic Stress Disorder

CPTSD is formally recognized as a diagnosis in the 11th edition of the *International Statistical Classification of Diseases and Related Health Problems*[1] (ICD-11; World Health Organization, 2022), although not in DSM-5-TR. ICD-11 has formalized a conceptual distinction that has long been proposed, that individuals exposed to *chronic and/or prolonged* exposure to traumatic events differ in presentation from those individuals exposed to a single traumatic incident or a discrete set of traumatic experiences. PTSD was more typically associated with these kinds of discrete experiences. Events associated with complex trauma, on the other hand, include prolonged traumatic exposure such as childhood sexual, physical, or emotional abuse; torture; prisoner of war situations; or being a victim of sex trafficking or intimate partner violence (see Brewin et al., 2017, for a review).

The term "complex PTSD" was first launched by Herman (1992) and was assumed to develop following the experience of severe interpersonal traumatic exposure, such as that mentioned earlier. The acute stressors associated with complex trauma are repetitive or prolonged, often involve harm or abandonment by caregivers or other ostensibly responsible adults, and often occur at developmentally vulnerable times in a victim's life, such as early childhood or adolescence.

[1]ICD is the diagnostic system that all insurers in the United States use, as do all hospitals and many clinics, as well as clinicians in private practice. It is a diagnostic system that includes both mental health and physical health disorders and is used by all disciplines (psychiatry, cardiology, immunology, gynecology) in hospital and clinic settings. Clinicians may choose to use either ICD or DSM in diagnosing and submitting insurance claims.

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Core problems of affect dysregulation and emotional instability, impaired self-development, structural dissociation and periods of amnesia, somatic dysregulation, and disorganized attachment patterns are frequently seen among survivors of complex trauma. Basic trust in relationships is often compromised, leading to problematic interpersonal connectedness. Some individuals avoid relationships or feel incapable of getting and staying close to others, often because managing conflict and engaging in authentic communication produces fear or anxiety. Others may actually deride or belittle relationships due to past disappointments. CPTSD reflects these experiences, among other challenges. Survivors with CPTSD often harbor feelings of guilt, shame, or lack of self-worth, along with more extreme distortions of perspective, including distorted beliefs about themselves and those who perpetrated harm. CPTSD may include intrusive reexperiencing of the trauma, as in PTSD, but coupled with these other, significant disruptions in functioning.

ICD-11 CPTSD comprises core ICD-11 PTSD symptom clusters (reexperiencing, avoidance, sense of threat), as well as three problem domains in "disturbances in self-organization": (1) affect dysregulation, (2) negative self-concept, and (3) interpersonal difficulties (Maercker et al., 2013). CPTSD symptoms represent a broader spectrum of problems that acknowledges not only the role of traumatic stressors in generating horror and fear, but also the consequences that exposure to sustained, repeated, or multiple types of traumatic stressors have on self-organization, particularly when they occur during childhood.

Cloitre, Garvert, Brewin, Bryant, and Maercker (2013) describe the "disturbances in self-organization" domain problems as emotion dysregulation, as evidenced by heightened emotional reactivity, violent outbursts, reckless or self-destructive behavior, or a tendency toward experiencing prolonged dissociative states when under stress. In addition, there may be emotional numbing and a lack of ability to experience pleasure or positive emotions. Self-disturbances are characterized by negative self-concept, marked by persistent beliefs about oneself as diminished, defeated, or worthless. These can be accompanied by deep and pervasive feelings of shame or guilt related to, for example, not having overcome adverse circumstances or not having been able to prevent the suffering of others. Interpersonal disturbances are defined by persistent difficulties in sustaining relationships. These difficulties may present in a variety of ways but are exemplified by difficulties in feeling close to others. Individuals may consistently avoid, deride, or have little interest in relationships specifically and in social engagement more generally. The person may occasionally experience close or intense relationships but will have difficulty maintaining emotional engagement.

DSM-5-TR declined to recognize CPTSD as a separate diagnosis but incorporated some of the observed symptoms into PTSD through the

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addition of the symptom cluster that focuses on thought patterns and moods related to shame and guilt. There is now also a subtype for those who suffer with significant dissociative experiences/symptoms, represented by symptoms of derealization and depersonalization.

An accumulating substantial literature indicates that individuals with CPTSD are more likely to have experienced prolonged trauma than those with PTSD, supporting the conceptual basis for this distinction (see Brewin et al., 2017). Although CPTSD as a diagnosis distinct from PTSD remains controversial at this time, we include it here because of its utility in formulating the relationship between traumatic stress response and substance misuse; many underlying features of chronic trauma exposure and problematic substance use are shared by those clients struggling with both concerns. The practical clinical benefit of this distinction is that it can facilitate more refined characterization of symptom profiles that belong to subgroups of survivors of trauma and, most importantly, help shape more personalized, effective, and efficient treatment plans.

Additional diagnostic debate has focused on the overlap in symptoms between borderline personality disorder (BPD) and CPTSD. Individuals with BPD often frantically avoid real or imagined abandonment; experience intense, often unstable interpersonal relationships; demonstrate impulsivity and intense anger, identity disturbance, and unstable sense of self, chronic feelings of emptiness, stress-related paranoia-like ideation, and difficulty managing intense emotion and distress; and dissociation.

BPD has not specifically been associated with a traumatic etiology, although there is significant comorbidity. Roughly two-thirds of individuals diagnosed with BPD have been exposed to prolonged childhood maltreatment, abuse, or witnessing partner violence between their caretakers (Herman, Perry, & van der Kolk, 1989). The overlap in symptoms and the high levels of comorbidity have led many people to consider whether what we have called BPD in many clients would be better accounted for by CPTSD, without the profound negative stigma that has come to be associated with BPD.

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Perspectives on Substance Use Disorders and Substance Misuse

We now have a much greater awareness that problematic substance use must be considered *on a continuum*. Changes to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) furthered our ability to conceptualize substance misuse this way and to diagnose substance use disorders (SUDs) along a spectrum. Prior

diagnostic approaches provided two categorical options: whether a person met criteria for "substance abuse" or "substance dependence." DSM-5 and subsequently DSM-5-TR approach problematic substance use and the ability to diagnose an SUD along a continuum. A diagnosis of an SUD is based on the number of endorsed deficits associated with difficulty controlling one's use, impact on social functioning, use of substances in ways that impose risk, and evidence of physiological tolerance or withdrawal, classifying the SUD on a continuum from mild to severe. This approach recognizes that even a "mild" SUD is worthy of clinical attention.

The Abstinence-Only Approach

Abstinence-only approaches have long been seen by many as the only way to address problematic substance use. In response to early *moral theories* of addiction, in which the misuse of substances was seen as a sign of weak moral character and lack of willpower, abstinence was seen as the righteous response to a life of alcohol-infused dissolution. Individuals were often directed to the church to stop what was seen as sinful behavior. This belief was instrumental in the movement toward Prohibition. Abstinence further took hold several decades later as alcoholism was considered a physical malady (Silkworth, 1937), and the *disease model* of addiction emerged (Jellinek, 1960), identifying addiction as a chronic physical illness. While minimizing the *moral* stigma attached to substance use by emphasizing that addiction was an *illness* that could be treated, the disease model supported the notion that individuals could never be cured of their substance use problem and that the only appropriate response was ongoing abstinence from all substances. From this perspective, one could never return to a moderate level of use. Recovery came to be seen as a lifelong process.

Alcoholics Anonymous emerged embracing these principles, which have remained foundational components of 12-step groups. The only requirement of membership in 12-step groups is the desire to STOP using. Many programs that emerged to treat addiction incorporated the disease model and 12-step philosophy into their treatment approaches, and abstinence as the only acceptable goal for treatment was perpetuated. The 12-step approach has been helpful to many individuals. From a public health standpoint, however, attempts to reduce or eliminate substance misuse through abstinence-focused or moralistic treatment approaches, along with efforts to criminalize drug use, have often failed.

The Harm Reduction Approach

In contrast to abstinence-only models, harm reduction approaches evolved to provide a new way to mitigate the harmful consequences of substance use,

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without demanding abstinence. Harm reduction has been defined as "a set of compassionate and pragmatic approaches for reducing harm associated with high-risk behaviors and improving quality of life" (Collins et al., 2012, p. 5), and has filled a gap in how we approach substance use. Harm reduction has placed an emphasis on the consequences of misusing substances rather than vilifying the substances themselves.

Indeed, important national organizations such as the NIAAA (2021) have begun to support revised views on "recovery" that do not presuppose abstinence: "Recovery is a process through which an individual pursues both remission from alcohol use disorder (AUD) and cessation from heavy drinking. An individual may be considered "recovered" if both remission from AUD and cessation from heavy drinking are achieved and maintained over time."

Public health harm reduction initiatives have also demonstrated the value of the harm reduction concept. A striking public policy example was associated with the surge in HIV/AIDS infections, in which intravenous drug use posed a particular public health risk through the use of shared needles. By offering harm reduction services, such as medical care and clean syringes, and lowering barriers for methadone treatment, programs in the United Kingdom demonstrated the effectiveness of a harm reduction approach to both individuals and to society; while HIV/AIDS rates soared among intravenous drug users globally, the United Kingdom was able to dramatically limit the transmission of disease associated with intravenous drug use.

More recent public health efforts at harm reduction for opioid users include the distribution of clean needles and items to help individuals inject more safely, and initiatives to develop safe consumption sites. In countries where safe consumption sites are available (e.g., Canada, Australia, parts of Europe), individuals are able to consume or inject substances with sterile injection supplies, and with onsite addiction peer specialists and providers to deliver immediate reversal care in the case of opioid overdose. With access to these sites, fewer individuals use substances in public spaces, transmission of disease is decreased as individuals learn safer injection practices, mortality following overdose is reduced, and fewer syringes are discarded in public spaces. Personnel at safe consumption sites are also able to make referrals to treatment facilities. The United States has faced opposition to the adoption of these sites, but their harm reduction efficacy elsewhere is well documented (see Finke & Chan, 2022).

We advocate a harm reduction framework for assessment and treatment of substance misuse that recognizes the continuum of severity and provides the flexibility to let treatment unfold according to the needs and desires of the client. It has been helpful in allowing clinicians to respond to substance misuse without insisting on abstinence, even though many clients may choose abstinence as the best goal through a harm reduction approach.

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A central principle of harm reduction psychotherapy (Tatarsky & Kellogg, 2012; Tatarsky, 2002) includes *not holding abstinence as a necessary precondition for treatment*. An alternative to a one-size-fits-all stance about how substance misuse should be treated, a harm reduction framework enables us to individualize treatment timing, goals, and planning.

Understanding the Complexity of Problematic Substance Use

The emergence of the *biopsychosocial model* also broadened the perspective on problematic substance use. The moral model and the disease model presented a limited perspective on the development of substance misuse. While the contribution of genetics and the physiology of the body and brain remains vital in understanding problematic substance use, it is one part of a complex interaction among biological, psychological, and social-environmental vulnerabilities. The biopsychosocial model attends to the unique matrix of contributing factors that helps us to formulate how substance use came to play such an important role for an individual and how it continues to be maintained. Psychological components cover as broad a range as the field of psychotherapy itself, incorporating attention to development, personality, emotion, cognition, and relational and ecological factors surrounding the individual, reflecting the complexity of an individual's past and present (see DiClemente, 2018). Trauma, particularly early childhood trauma and prolonged maltreatment, intersect with all of these elements, potentially derailing development. The resources and responses of those around individuals as they grow contribute to an environment of resilience or deficit, and whether substances may become a seemingly adaptive resource.

Several psychoanalytic writers have proposed an understanding of how substances could become an appealing means of *self-medication* (Khantzian, 1985) in response to deficits in affect regulation. Khantzian (1997) noted how substances are often used to manage interpersonal struggles, problems in identity and self-esteem, and self-care. Wurmser (1974) described intolerance of unpleasant affect states as a contributing factor in the urge to use substances, and Krystal and Krystal (1988) likewise pointed out how a person might soothe his emotional distress by substituting substances for his own inability to self-soothe or failure to receive soothing from others. Substances were seen as a means of tolerating and modulating uncomfortable emotion, often by specifically choosing a substance to meet a given emotional need (e.g., a depressant type substance such as alcohol or opioids to calm a state of agitation and distress, a stimulant to counter feelings of sadness or numbness). Unfortunately, over time, what seems initially to be "adaptive" substance use frequently becomes problematic. These perspectives underlie the self-medication model for understanding the relationship between substance misuse and trauma described below.

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Interrelationship between Traumatic Stress and Substance Misuse

At this time, the high rate of co-occurrence between PTSD and SUD is undisputed. Rates of trauma exposure among adults with SUD are estimated to be as high as 95% (e.g., Dansky et al., 1995; Hien et al., 2021; McCauley et al., 2012; Norman et al., 2019), Among individuals with SUD, the prevalence of lifetime PTSD is estimated to be between 26 and 52%, while the prevalence of current PTSD is estimated to be 15 to 42% (Dragan & Lis-Turlejska, 2007; Driessen et al., 2008; Hien et al., 2021; Norman et al., 2019; McCauley et al., 2012; Reynolds, Hinchliffe, Asamoah, & Kouimtsidis, 2011; Schäfer et al., 2010). Among individuals with PTSD, the prevalence of co-occurring SUD, including AUD, is estimated to be between 36 and 52%, substantially higher than general population rates (Mills, Teesson, Ross, & Peters, 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011).

The majority of clients, often upward of 70% (see Hien, Litt, Cohen, Miele, & Campbell, 2009) in substance use treatment settings, report at least one, if not multiple, lifetime exposures to trauma. Thus, many of the psychological problems encountered by providers treating clients, especially women, in community-based substance abuse programs are long-standing and the result of early-onset, chronic and repetitive physical or sexual trauma, including family violence, incest, and/or severe childhood neglect. Given the severity and repetitive nature of the traumatic experiences, which most often precede the start of substance misuse, adopting a stance that incorporates a complex trauma or CPTSD lens will be important in the assessment and treatment planning phases of care.

Pathways between Trauma and Substance Misuse

Helping to articulate the ways that trauma and substance misuse may have been interconnected during a client's life history is a crucial part of disentangling and reshaping a narrative of recovery over the course of treatment. For many clients, early presentation of their history/story in treatment often includes little clarity and/or differentiation of trauma-related and substance use episodes and symptoms; the narratives tend to be confusing and experiential. Treatment can help clients begin to articulate and track how their traumatic stress symptoms are linked to their decision making around substance misuse. Often, clients do not even recognize that how they are feeling may be trauma-related (e.g., dissociative moments, emotional dysregulation, hyperarousal).

Multiple pathways of disorder onset and maintenance are useful to consider in approaching therapy and developing a meaningful treatment plan. Understanding these frameworks can help clinician and client begin to

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recognize the connections between seemingly disparate symptoms, conditions, and experiences. Garnering considerable empirical support are three prevailing models for causal pathways and temporal relationships (see Figure 2.1): *shared liability*, *self-medication*, and *high-risk*.

The *shared vulnerability or shared liability model* (Hien et al., 2021; Haller & Chassin, 2014) speaks to the complex developmental underpinnings of each condition, often developed over many years, for some clients starting in early childhood. Longitudinal studies with large datasets have revealed that childhood exposure to traumatic life events (distinct from trauma exposure in adulthood) has been shown to increase the likelihood of adulthood mental health, as well as physical health, disorders, with single and multiple comorbidities, including alcohol and SUDs (Dube, Anda, Felitti, Edwards, & Croft, 2002; Young-Wolff et al., 2011). These findings support a model whereby early stress exposure leading to PTSD increases the vulnerability to develop SUDs (e.g., Kendler et al., 2000). A complex, reciprocal, and reinforcing relationship between traumatic stress exposure and SUDs (Norman et al., 2012; López-Castro et al., 2015) suggests multiple vulnerability factors including genetic, neurobiological, childhood history, and familial factors, among others. Identifying these factors with clients in treatment helps to provide a greater understanding of some of the contributors leading to their substance use and misuse.

Relatedly, the *self-medication model* (Khantzian, 1997), as detailed previously, also takes a developmental view, connecting the use of substances to managing underlying trauma-related emotional and mental health symptoms. In support of this clinical theory, a direct relationship has been observed between PTSD and the later development of SUDs (e.g., Chilcoat & Breslau, 1998). In several large-scale studies (e.g., Back, Brady, Sonne, & Verduin, 2006; Hien et al., 2010), a prior diagnosis of PTSD predicted the later findings of moderate to severe alcohol or drug use problems, as well as use of substances to cope with other mental health conditions, such as anxiety or depression.

In addition, how the use of substances may have led clients into dangerous contexts or to behaviors that resulted in some type of violence or trauma exposure has been referred to in the literature as the *high-risk model* (Haller & Chassin, 2014). The choice to use substances and any associated trauma that can occur in that context is often accompanied by shame and self-blame ("If only I hadn't been drunk, none of this would have happened.") that becomes an important focus of treatment.

Each of these models offers a different perspective on the ways that trauma, related symptoms, and use of substances may be connected for a client. As we saw with both Ms. A and Mr. B, elements of each model were present in the case formulations. As with both cases, and many other like them, these relationships may change over the course of someone's life, and

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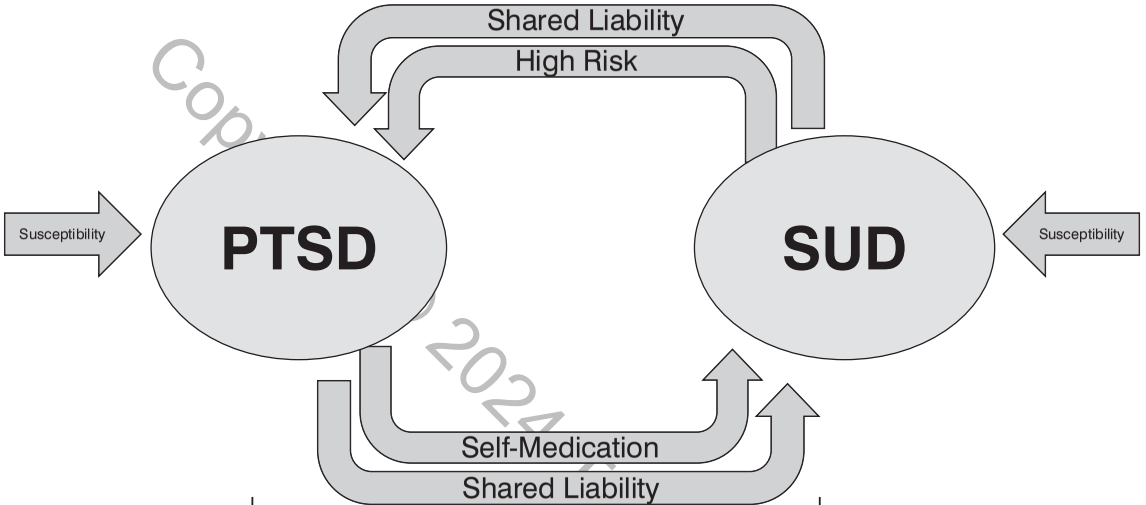

Model	Description	Evidence
Self-Medication	A prior diagnosis of PTSD predicted the later findings of alcohol or drug use disorders.	Khantzian (1997); Chilcoat & Breslau (1998); Back, Brady, Sonne, & Verduin (2006); Hien et al. (2010)
Shared Liability	A complex, reciprocal, and reinforcing relationship between traumatic stress-related disorders and SUDs.	Norman et al. (2012); López-Castro, Hu, Papini, Ruglass, & Hien (2015); Gilpin & Weiner (2017)
Susceptibility	Early stress exposure leading to PTSD increases the vulnerability to develop SUDs.	Kendler et al. (2000); Young-Wolff, Kendler, Ericson, & Prescott (2011)
High-Risk	Substance intoxication and/or other high-risk contexts (e.g., drug-related crime) lead to trauma exposure and development of PTSD.	Davis, Stoner, Norris, George, & Masters (2009); Haller & Chassin (2014); Windle (1994)

FIGURE 2.1. Pathways between traumatic stress and substance use. From Hien et al. (2021). Copyright © 2021. Reprinted with permission from Elsevier.

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even over the course of treatment, particularly as ongoing or progressive substance misuse places a client at risk of further traumatization, and as unremitting PTSD and other mental health symptoms encourage continued substance use. There is evidence of a dose–response effect over time of added levels of trauma and stress exposure leading to more severe PTSD and other forms of psychopathology.

Ms. A presented to treatment with a primary AUD. The relationship of her escalated drinking to her response to having been sexually assaulted was quickly made clear, however, supporting a self-medication understanding of her current level of alcohol use. Ms. A was motivated to use substances to blunt traumatic stress symptoms and to help her aspire to a semblance of "normality" by going out and having fun. While temporarily effective, Ms. A's use quickly spiraled out of control during episodes of binge drinking. Moreover, some substances (e.g., cocaine) can intensify PTSD symptoms, particularly hyperarousal (Khoury, Tang, Bradley, Cubells, & Ressler, 2010), augmenting rather than mitigating distress.

As Ms. A frequently found herself in situations in which her level of intoxication put her at increased risk for additional trauma—at times she was intoxicated to the point of blacking out, losing her belongings, waking up in unexpected places—the high-risk model might also have been explanatory. Ms. A was fortunate not to have incurred additional trauma, but clients are often revictimized in situations like those of Ms. A, exacerbating PTSD and leading to further substance use and additional feelings of self-recrimination.

For Mr. B, the impact of early neglect and childhood sexual abuse on his initiation to substance use and escalating substance misuse supports a self-medication model, as well as models of shared vulnerability or shared liability, and later high risk. These early experiences impacted his personal and professional development. After graduating, Mr. B worked at a retail store. His drinking interfered with his ability to perform at his job. He often arrived at work hungover and was reprimanded for being late or not being more outgoing with customers, and was eventually fired. Mr. B's drinking continued to escalate throughout his 20s to the point that he was drinking heavily, hard alcohol almost daily. He tried to cut back on his drinking after a series of "very bad nights" that involved some scary situations in which he blacked out and woke up in unfamiliar places. He described wanting to drink more moderately but found it difficult, especially in the context of friends who drank heavily. "It felt like a choice between drinking or not having a social life." This continued to put Mr. B at risk of further harm.

Overlapping Needs

Historically, mental health care and treatment for SUDs were in separate "silos," with little treatment integration. This split held true for treatment needs related to traumatic stress and PTSD, as well as many other mental

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health presentations. Clients with PTSD who presented to mental health programs with co-occurring substance misuse were often directed to substance use treatment facilities. They were told that they needed to "get clean first," before they could work on their PTSD. Meanwhile, clinicians in the substance use treatment settings often lacked the expertise to address traumatic stress. As a result, clients often dropped out of treatment; they were being asked to discontinue their substance use, without proper attention to their PTSD. An effort to move toward a "no wrong door" approach, in which clients can find the therapy they need wherever they present for treatment, has begun to infiltrate the treatment community. More programs that treat substance misuse are at least able to provide a trauma-informed environment that recognizes the impact of trauma and attends to the impact of trauma on substance-using behavior.

Fundamentally, though, there are a number of overlapping areas of clinical need in the treatment of traumatic stress and substance misuse (see Figure 2.2 for some examples). Together, these symptoms and conditions further underscore the rationale for an integrated treatment approach. For example, a central feature that we have identified among trauma survivors, particularly those with CPTSD, is difficulty managing distress. Particularly those clients with childhood maltreatment have difficulty identifying their feeling states, tolerating negative affect, and managing dysregulated emotions. These are among the driving factors leading many clients to self-medicate with alcohol

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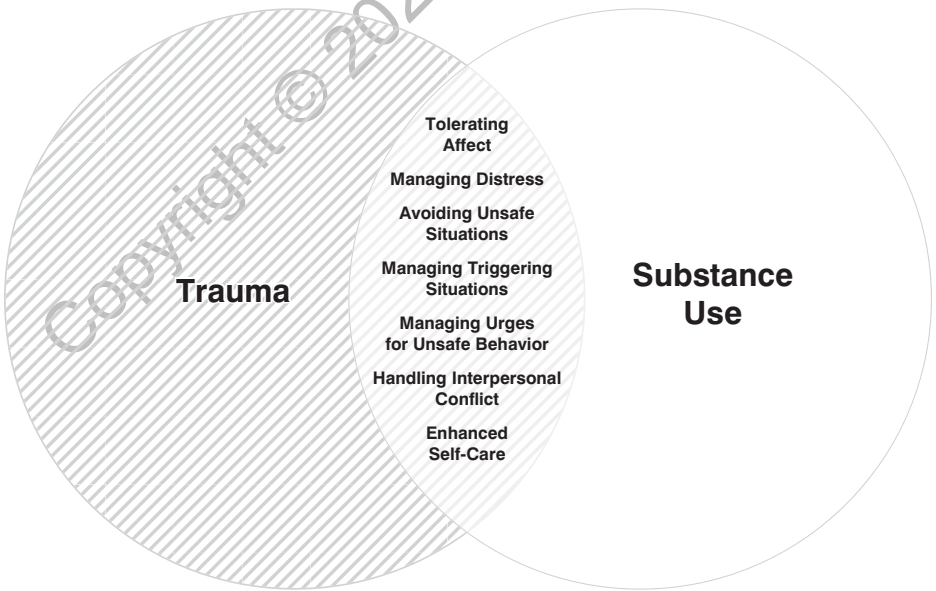

FIGURE 2.2. Overlapping needs related to traumatic stress and substance use.

or other substances, or other maladaptive behaviors used to self-soothe. Helping clients to better manage these domains so that they can downregulate without the use of substances has the potential to reduce PTSD and enhance recovery from substance misuse.

> Ms. A came to realize how difficult it had always been for her to sit with discomfort, and how tempted she was to cut ties from those who caused her emotional upset. She also had difficulty identifying how she was feeling and struggled to go beyond describing her feelings as "upset." Ms. A worked hard to distance herself from discomfort. Friends had pointed out to her how good she was at appearing happy, even when she was not; she learned to push her feelings "below ground." She cultivated a kind of detached bravado in the face of difficult experiences. This was clear in her response to the rape. Ms. A told no one what had happened and immediately went back to her daily routine. After the trip, she went right back to her schoolwork.
>
> In treatment, we noticed how Ms. A would present painful and depressing material with incongruent affect and laughter. She began to see how she sought to deflect any vulnerability with others. Ms. A reflected on how she literally would perch on the edge of her chair in therapy, rather than allow herself to sink back into the chair and more fully engage in treatment. She revealed her ongoing discomfort with opening up in therapy over the years, as it always felt unsafe.
>
> Treatment sought to help Ms. A to recognize, identify, and tolerate how she was feeling. As she began to have a greater vocabulary for her emotional experience and less need to disconnect from her feelings, Ms. A also expressed greater comfort with who she was and what she wanted for herself.

Identifying and managing unsafe or high-risk situations is another important area of overlapping need. For those misusing substances, addressing this is a primary therapeutic goal. Most cognitive-behavioral treatments for substance misuse (explored in Chapter 6) recognize the difficulty that clients face in identifying situations that put them at risk of using, and how to avoid or better manage those unsafe situations. Managing situations that trigger clients to want to drink or use drugs is difficult for clients who have not learned how to manage their cravings and urges. PTSD sometimes presents similar challenges, as clients have to contend with urges to engage in unsafe behaviors or substance use, and frequently do not know how to avoid or manage risky situations or situations that trigger their own traumatic stress responses (e.g., intrusive memories, avoidance, self-blame, hyperarousal).

Both substance misuse and trauma exposure are often associated with interpersonal difficulties. Managing interpersonal conflict, in particular, is very stressful and tied to difficulties in affect regulation, as well as other deficits in communication and assertiveness. Part of managing high-risk situations involves navigating interpersonal dynamics, including how to

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effectively refuse substances or assert one's needs. Similarly, clients' ability to engage in self-care is often compromised by trauma and substance misuse, and is an important component of treatment. Even prior to her sexual assault, Ms. A experienced anxiety in social situations and had begun to use alcohol to help her feel more at ease, particularly in contexts that involved meeting potential partners, and to assuage some of the internal conflict she felt as a queer woman. Following the sexual assault, her reliance on alcohol in these situations intensified.

Nature and Severity of Exposure to Trauma

The range, type, and severity of mental health impairment differs for each client depending on the nature of trauma exposure and the impact of the traumatic experiences. Many clients presenting with trauma exposure come to us with long-standing childhood histories of maltreatment that may or may not have been explored. The Centers for Disease Control and Prevention–Kaiser Permanente Mortality and Morbidity Study revealed the ubiquity and negative health and mental health impacts of many types of early childhood adversity (adverse childhood experiences [ACEs]; Fellitti et al., 1998) that, in addition to the experience of abuse and neglect, also included parental substance misuse, mental illness, parental separation/divorce, and having a parent in prison. Some key risk factors that are important in formulating an approach to treatment include the severity and unpredictability of the traumatic events and whether there was prior childhood trauma exposure, preexisting psychiatric conditions, or social/familial support. Cumulative or repeated victimizations are also frequent in our clients' histories and are much more likely to result in PTSD and/or substance misuse or SUDs (Fellitti et al., 1998). Treatment is clearly indicated when trauma-related symptoms make it difficult for an individual to function at normal capacity. This is true of full-blown psychiatric sequelae of trauma exposure such as PTSD (e.g., intense fear, persistent avoidance of trauma-related stimuli that interfere with daily activities, social withdrawal and immobility, hyperarousal), major depression (e.g. hopelessness, suicidal thoughts/feelings), and chronic grief, among other conditions.

Reactions to a traumatic event directly influence the likelihood of developing PTSD (Irish et al., 2011) and may also uncover how substance use and misuse develop as coping strategies for the client. Affective reactions, dissociation, and cognitive appraisals of a traumatic event are three common peritraumatic and posttraumatic reactions that contribute to the likelihood of PTSD development and, as such, are important to explore. Evaluating the immediate emotional responses to trauma, the degree of dissociation, and how the client appraises the traumatic event may be important avenues for "uncovering," or helping clients to learn about themselves in the treatment process.

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Trauma-Related Comorbidity

Clients who present with diagnosable PTSD and SUD (see Chapter 3 for details of how to approach the assessment and diagnosis of PTSD and SUDs in clinical practice), are likely to meet diagnostic criteria for a number of other co-occurring conditions, notably depression (i.e., sleep disturbance and social withdrawal) and other anxiety disorders (i.e., panic attacks and avoidance) (e.g., Gielen, Havermans, Tekelenburg, & Jansen, 2012; McGovern et al., 2015; Ruglass et al., 2017). Based upon findings from the National Comorbidity Study (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), approximately 80% of individuals with PTSD meet criteria for at least one other psychiatric diagnosis, with 17% having one other diagnosis, 18% having two other diagnoses, and 44% having three or more additional diagnoses. The most common comorbid conditions with PTSD are SUDs (28% AUDs, 27% SUDs), affective disorders (49% major depression, 23% dysthymia, and 6% mania), and other anxiety disorders (ranging from 15% with generalized anxiety to 28% with social phobias, and 29% with simple phobias). According to one national epidemiological study, 46.4% of individuals with lifetime PTSD also met criteria for SUD (Pietrzak et al., 2011).

Three patterns of lifetime comorbidity associated with PTSD (Galatzer-Levy, Nickerson, Litz, & Marmar, 2013) provide guidance for clinicians in early conversations with clients about their life histories and substance use: (1) high comorbidity: mood and anxiety disorders; (2) high comorbidity: mood, anxiety, and SUDs; and (3) low comorbidity: "pure" PTSD. Importantly, each of the two high-comorbidity patterns have shown significantly more severity in terms of PTSD symptoms, suicidal ideation, and domestic violence compared to the pure PTSD group.

Although overall comorbidity rates do not appear to differ for men and women with PTSD, the *types* of associated disorders do. Women, in particular, are more likely than men to have PTSD as their primary diagnosis with other comorbid conditions, and their typical drinking pattern is more likely to be episodic binge drinking rather than heavy drinking, at least initially (Peirce, Kindbom, Waesche, Yuscavage, & Brooner, 2008). In general, women are two times more likely than men to meet criteria for a depressive disorder, whereas among individuals *with PTSD*, women and men have concurrent depressive disorders at equal rates (Brady, 1997; Kessler et al., 1995). In line with national epidemiology estimates, men with PTSD are more likely to be diagnosed with antisocial personality disorder, but women with PTSD are more likely to be diagnosed with panic disorder and BPD (Keane & Kaloupek, 1997; Kessler et al., 1995).

The relationship between PTSD and other associated disorders is often quite complex, as is the course of multiple illnesses. Whereas some individuals presenting with PTSD had preexisting psychological problems prior to exposure to trauma, others developed additional disorders secondary to the

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traumatic events and/or the onset of PTSD and its often-debilitating symptoms. There are also those for whom PTSD and related psychiatric conditions developed simultaneously in response to trauma exposure.

A more current perspective on clients who meet criteria for multiple comorbid disorders is to consider how they might better be recognized as suffering from a complex range of trauma-related problems rather than conceptualizing each set of symptoms as separate and discrete disorders (van der Kolk, McFarlane, & Weisaeth, 1996). We now recognize that exposure to early, severe, and chronic trauma is associated with developmentally driven adaptations to trauma. A growing literature on childhood trauma exposure and later disruptions in HPA axis (hypothalamic–pituitary–adrenal) functioning provide further support for the notion that early trauma "resides in the body," with long-standing psychological *and neurobiological* impacts on developmental processes.

Related to these underlying neurofunctional and psychological impacts of complex trauma, personality disorders are often present in individuals with PTSD and SUD, in particular, antisocial personality disorder (APD) and BPD. BPD, we have noted, shares significant overlap with CPTSD. There are high rates of early life trauma (e.g., childhood sexual abuse, physical abuse, and witnessing violence) among individuals with BPD, and approximately half of individuals with BPD also have PTSD (e.g., Scheiderer, Wood, & Trull, 2015).

Moreover, in the context of substance misuse, personality disorder features may become accentuated. Acute and chronic use of alcohol and/or drugs can influence and exacerbate symptoms of APD (e.g., unlawful behavior, repeated lying, impulsivity, reckless disregard for safety, repeated fights or assaults). Impulsivity, a feature of both SUD and BPD, can be exacerbated by intoxication.

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Traumatization and Microaggressions Related to Individual Differences and Diversity

In addition to the other traumatic life events our clients may have experienced, we note the high rates of racial trauma that we must keep in our mind as we approach and respect the life histories and experiences of our clients, regardless of income and socioeconomic status. We also recognize the racial inequalities in exposures to microaggressions and race-based trauma, and we know the importance of attending to our clients' multiple identities. Racial, ethnic, sexual, or gender orientations may have played a direct role in or been impacted by clients' "index trauma" (i.e., their primary trauma) or their trauma histories. For Ms. A, for example, her sexual attraction to men and women, and her experience of safety in relationships, was impacted by having been sexually assaulted by a man. Following the assault, Ms. A was fearful

and avoidant of men. For Mr. B, in his 1-year treatment, a relapse to drinking occurred after a racial traumatic event in which he was falsely accused of shoplifting while shopping in a store, and this was not the first time he experienced being targeted because of his race.

For many clients, multicultural identities have been shaped around their index traumas. For example, among those ethnic or racial minoritized individuals who might also be from lower income neighborhoods, exposure to community violence, challenges of immigration, racism, discrimination, and a host of other stressors provide a distinct backdrop for cumulative trauma on a multisystemic level. Indeed, Mr. B came to feel that his availability to his neighbor was a consequence of racial inequities that made it more difficult for his mother to find appropriate mental health care and the neglect that followed when she became depressed, withdrawn, and unattentive.

Considering racial discrimination in the lives of our clients may provide a key contextualization for gaining a more complete understanding of the associations between their traumatic stressors and their substance use. It has been identified that racial discrimination can be similar to a DSM-5-TR traumatic event, whereby racism and discrimination threaten the safety (real or perceived) that affects a sense of integrity (i.e., Carter, 2007; Carter & Sant-Barket, 2015). The term "race-based traumatic stress" has been promoted as a way of referring to race-based events that can have a negative mental health impact and even lead to PTSD, depending on their frequency, intensity, and severity (Polanco-Roman, Danies, & Anglin, 2016; Chavez-Dueñas, Adames, Perez-Chavez, & Salas, 2019).

Summary

In this chapter we have presented a number of models for considering the relationships between traumatic stress exposures and use/problematic use of substances as they may present clinically and symptomatically in the consulting room. We provided the reader with research findings that indicate the prevalence of this comorbidity, emphasizing the science that underpins the importance of a flexible and open therapeutic stance. Providing the client with psychoeducation of how these conditions may interweave throughout treatment, and indeed throughout the client's life, can also be helpful. In Chapter 3, we propose that assessment is a critical early and ongoing part of the treatment process for our clients. We will discuss ways that assessment and case formulation can be conducted to facilitate our clients' understanding of the origins and presentation of their symptoms as they strive for wellness and recovery.

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