June 2011

Alumni News…

the journey continues

Gratitude

Gratitude is defined as thankfulness or appreciation. I've heard gratitude described in meetings as an action. Just saying we are grateful is nice but showing gratitude brings our recovery to a higher level. When spiritual, emotional and physical sobriety is achieved there is a desire to show our indebtness. There are a million ways to show appreciation for our recovery and sobriety. One way is to serve others. In recovery we can do that by sharing our experience, strength and hope, by sponsoring, leading meetings, cleaning up, making coffee, donating money (7th tradition), becoming a trusted servant and many more. In life we can show gratitude in being helpful to others in anyway that is useful. My wish for you this beautiful season is that you find many things in your life to be thankful for. A grateful life is a full life. G.B. Stearns says, " Silent gratitude isn't much use to anyone." Share the gratefulness and joy of recovery with those around you. You will be stronger and happier for it.

Cottonwood is a unique, authentic, life changing, remarkable experience. If you want or need assistance please let us help you. If you have any questions, please contact me at shicks@cottonwoodtucson.com or call 520-743-0411 extension 2517.

Be well, Sally

Posttraumatic Stress Disorder in the Chemically Dependent Client

By Kathleen Parrish, LPC and Jeffrey C. Friedman, LISAC

The instinctive response to trauma is to cover it over, to bar its memories from consciousness. Even with the mind-numbing effects of drugs and alcohol – used in a desperate effort to sooth the painful emotional legacy of past violence or neglect – these memories refuse to stay buried. Like restless ghosts seeking release, these emotional and somatic recollections of trauma stir at the edges of awareness, imploring the traumatized to tell their terrible and long-buried truths. To help the process of acknowledging, giving voice to and managing these memories in a way that does not jeopardize the fragile process of early recovery is a primary challenge facing the clinician working with trauma clients. In the therapeutic setting, a carefully crafted and skillfully executed treatment plan can be a key component of a recovery effort for those suffering from addiction and Posttraumatic Stress Disorder (PTSD).

The treatment of Posttraumatic Stress Disorder in chemically dependent patients can be a perplexing task for clinicians involved in their treatment. Not only must therapists appreciate the role PTSD can play in the addictive process, but they must also be cognizant of possible personality level dynamics, while skillfully addressing the patient's distressful feelings and often self-defeating behavior patterns that can linger well into the treatment experience, despite the clinician's best efforts.

Optimal therapeutic strategies used in the care of traumatized chemical dependency patients address not just the trauma itself, but also any trauma-driven behavior that might sabotage recovery. Clinicians are also well advised to focus the recovery plan on helping the client develop more adaptive ways of coping with the challenge of traumatic memories and resulting negative core beliefs. The plan should also include teaching patients more adaptive self-soothing skills as well as helping them restructure negative beliefs.

Addiction and PTSD

The relationship between trauma and addiction is complex and even synergistic. Some therapists ask whether substance abuse in the traumatized patient is not just a symbolic reenactment of their initial abuse (Herman, 1992).

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Whether or not this is true, it is well understood that adult victims of childhood trauma, while in active addiction, often live in a world of violence and exploitation. Exposure to environmental stressors like these can trigger distressful PTSD symptoms, resulting in an accelerating downward spiral into ever more compulsive use of drugs and alcohol (Blank, 2006). Research also suggests that trauma can produce, in some people, an enduring disregulation of endorphin activity in the victim's brain, creating a plausible neurophysiological predisposition for opiate abuse in these patients (Pittman, van der Kolk, et. al 1990).

Research has shown high levels of co-morbidity among the chemically dependent population in regard to PTSD. Najavits, Weiss, Shaw, and Muenz, (1998) report that [patients] with current PTSD comprise 30-59 percent of substance abuse treatment samples. They also note that, among women with PTSD, Substance Use Disorders (SUD's) are 1.4-5.5 times more prevalent than among women without PTSD.

The exact cause(s) of PTSD are yet unknown, although researchers are now investigating a possible genetic predisposition, environmental causal factors, and gender-specific predisposing traits. Not everyone who experiences trauma will develop PTSD - and rates of PTSD tend to be a bit higher in women than among men. Men typically present with PTSD resulting from combat or accident related trauma, while women with PTSD more often report significant and more chronic sexual/physical abuse.

There also appears to be a link between early childhood trauma and the development of Borderline Personality Disorder (BPD). Zimmerman and Mattia, (1999) confirmed the presence of early developmental stage trauma in 85 percent of individuals who meet clinical criteria for BPD. Other disorders, such as depression, anxiety and panic disorders as well as disordered eating may also have a high rate of co-occurrence with PTSD and/or early childhood trauma.

Treatment Challenges

The high correlation between childhood trauma and BPD warns of a possibly complicated therapeutic process and guarded prognosis for a positive treatment outcome. Many chemical dependency patients with trauma and BPD will present with significant difficulty in functioning in the therapeutic environment. Profound fears of abandonment, and frequent mood instability coupled with an often, unpredictable vacillation between idealization and devaluation of the clinician can reduce the efficacy of the therapeutic diad. These interfering behaviors can spike during family sessions and trauma therapy, as painful memories are rekindled and clients process intense and often uncomfortable feelings.

Studies indicate that the use of containment skills to address treatment interfering behaviors can help to reduce occurrences of these behaviors and increase the client's awareness of their own body, mind, and emotions as well as their innate potential for wellness. Linehan (1993) suggests that Dialectical Behavioral strategies be incorporated to reduce self-harming behaviors and impulse control issues.

Because there is a likelihood that personality level dynamics might impinge on the treatment and recovery process, it seems wise, when treating traumatized substance-abusing patients, to focus on the implementation of soothing skills *prior* to an in-depth exploration of specific memories of trauma. This exploration should then be accompanied by a repeated and ongoing use of these skills - throughout the course of treatment and beyond. Structuring treatment this way makes for a therapeutic continuity that helps the client to feel more confident in their ability to manage the pain that can occur during an exploration of traumatic memories

.While the process of exploring the memories of trauma is going forward, twelve-step groups can offer support in understanding other behavioral issues, which may have ties to the original trauma, like chemical dependency or disordered eating. Once the recovery process has been established, the therapist should continue to proceed cautiously. An in-depth exploration of traumatic memories can spark an exacerbation of PTSD symptoms that can jeopardize the patient's fragile sobriety (Herman, 1992).

Even with the most carefully chosen and skillfully executed treatment plan, some patients continue to engage in behavior that is inconsistent with recovery and that can result in re-traumatization of self. Sadly, patients beset with residual and maladaptive patterns of behavior may be mislabeled as *treatment failures* or viewed as resistant and lacking in motivation.

What can appear to be resistance may be, instead, the individual's inability to moderate painful feelings and memories associated with the initial traumatic event. Patients who have difficulty in managing these feelings and memories often feel quite vulnerable and may lack key skills to effectively intervene on uncomfortable and distressing mood and affective states. They may also suffer from chronic depression and panic attacks, or engage in desperate and maladaptive self-soothing behaviors including self-mutilation, binge eating/purging, sexual compulsivity and compulsive spending

Treatment Strategies

Among the many therapies available to the addiction professional, narrative therapy stands out as an approach that can help the client to articulate their traumatic experiences. Giving voice to the trauma experience can diminish disturbing imagery, self-deprecating or intropunitive thoughts and feelings of guilt and shame. Narrative forms of therapy can also help the client to find words and a voice with which to tell their own story. This is a necessity for all who successfully recover from trauma.

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While narrative therapy represents a highly valuable strategy, the use of this approach alone can trigger PTSD symptoms or activate self-defeating behaviors. Many clients have "coped" with their trauma by abusing substances or engaging in other compulsive behavior. This kind of maladaptive coping, while it has allowed them an blunt the painful feelings associated with their original trauma, it quite likely resulted in self-inflicted secondary trauma. When individuals, who have been relying on mood-altering chemicals to keep unwanted feelings at bay, attempt to explore their trauma in therapy, they may become overwhelmed, or "flooded" by painful feelings before they have gained the ability to cope in more adaptive ways.

Meichenbaum (1994) suggests that Cognitive Behavioral Therapy (CBT) be used to teach clients to reduce arousal associated with traumatic memories. The focus of CBT can include challenging self-defeating thoughts that can lead to hasty, emotionally-driven decisions to use alcohol and drugs. CBT can also be coupled with relaxation and grounding exercises to allow clients to reconnect with their present physical reality instead of focusing on intrusive imagery (Gentry, 1998).

Other strategies for the treatment of trauma accompanied by addictive disorders include the concept of changing distorted thought patterns associated with the trauma. If therapeutic focus seeks only to process traumatic events and does not address the associated cognitive distortions, therapeutic interventions may serve only to strengthen core beliefs related to shame, self-hatred, and self-blame. Well-chosen cognitive interventions make for clarity and allow the client to move in the direction of healing and acceptance.

Conclusion

When treating addicted patients with PTSD and BPD, it is important for therapists to enter into caring, supportive, and structured therapeutic relationships, while maintaining and stressing proper limits and boundaries. The establishment and maintenance of good boundaries can allow clients a safe and structured environment in which to learn new values and mood intervention skills, as they begin to move away from the painful and destructive patterns of behavior. These newly recovering addicts and alcoholics are then free to cultivate an acceptance and understanding of the interaction between past and present while it promotes hope for the future.

When clients are able to moderate their own feelings and behaviors, they are better equipped to live substance-free and participate in healthy relationships while they honor their unique identities, strengths and past suffering.

Despite the challenges involved in the treatment of addicted patients suffering from PTSD and BPD, the process can be a rewarding one for the therapist. Well-chosen interventions can facilitate positive change in the lives of chemically dependent individuals with complex PTSD and BPD symptomology. While, in the past, treatment strategies have either ignored trauma altogether, or focused only on processing and resolving trauma, today's treatment emphasizes a more holistic approach while promoting the integration of containment skills, cognitive restructuring, and self-soothing techniques. This way is proving to be more successful in helping clients to cope with the aftermath of traumatic events while embracing a life of recovery, hope and healing

Kathleen Parrish, LPC *is a primary therapist at Cottonwood de Tucson, a behavioral health treatment facility in Tucson, Arizona. She specializes in the treatment of addiction and mood disorders in patients who have experienced trauma.*

Jeffrey C. Friedman, LISAC *is also a primary therapist at Cottonwood de Tucson. He has previously written articles for* Addiction Professional *on the special behavioral health needs of lawyers and Cottonwood's outreach effort involving a rehabilitation center in Mexico.*

Tucson Alumni Meetings

ATTENTION Tucson Alumni!

We are having many exciting and helpful presentations this year; here are the next three months provoking and inspiring presentations put together just for you.

July 6, 2011 "Just for the Fun of It" Fun and recovery all packaged together and presented by Butch (your favorite fun master)

August 3, 2011 " Brain Chemistry" by Jeff Friedman

September 7, 2011 "Playback Theatre", actors playback life experiences with humor and fun.

As always we will be meeting every Wednesday at 6:30 pm until 7:30pm on the Cottonwood campus to learn and share about how you can access and better develop those tools and strategies you received at Cottonwood. Recovery is a process and we can't do it alone. I hope you will come to share the unique experience that is the Cottonwood Alumni Meeting. Remember on the first Wednesday you can come at 5pm to have dinner with us., and feel free to bring one guest.

Keep Coming Back!

InnerPath Retreats

Beginnings & Beyond

6/27-7/1 • 8/1-5 • 9/ 19-23

Women's Retreat

6/20-24 • 7/25-29 • 9/12-16

Relationships Retreat

12/1-4

Developing Healthy Families

Monday - Friday
Contact us to schedule

We offer several 4 and 5 day programs for individuals, couples, and families who want to focus on codependency, relationships, communication, grief, loss, trauma, and anger. InnerPath is like a mini-Cottonwood experience where you can come back for a boost to your personal recovery plan. All of our retreats are held at the Cottonwood Nash House, meals and lodging included, and are limited to 8 people. Rokelle Lerner who is a therapist, author, and codependency expert, is our facilitator. Please contact **Jana Zeff** at 520-743-2141 or e-mail her at jzeff@cottonwoodtucson.com for more information about InnerPath.

Phoenix Alumni Meetings

Dear Phoenix Alumni,

I look forward to seeing and encouraging you as you continue your journey in recovery. We meet every first and third Tuesday night of the month at the **ABC Wellness office,** located at **7219 E. Shea Boulevard Scottsdale, AZ 85260.** The meeting time is from **7:00pm until 8:30pm**. The 2011 dates are listed below. Hope to see you there.

2011

Phoenix Alumni Meeting Dates

June 7 & 21 • July 5 & 19 • Aug 2 & 16

Sept 6 & 20 • Oct 4 & 18 • Nov 1 & 15 • Dec 6 & 20

Farmington/Durango Alumni Meetings

Dear New Mexico Alumni,

Hi alumni, I am looking forward to the July 25, 2011 Alumni meeting. The topic this month is, **"What Fears Are You Facing Today?"** We have a great group of alumni who are serious about supporting each other. The 2011 meetings will be held at the **First Baptist Church 511 W. Arrington, Farmington, NM. 87401**(west side of building) The meeting time is from **7:00pm until 8:30pm**. I hope to see you there, all are invited.

2011

Farmington Alumni Meeting Dates

July 25 • Sept 26 • Nov 28

CAP

What is **CAP?** Many of you may not have heard about this amazing program that is helping people discover the how and whys of what may be blocking them from living the life they deserve.

CAP is a four day intensive inpatient assessment program providing a comprehensive evaluation that will focus on the specific needs of the individual.

Cap is designed to meet the needs of the following:

- Cases of complex differentiated diagnosis
- Individuals with addictions or mental health issues who are not progressing in therapy
- Individuals who, following an intervention, may be willing to come for a thorough evaluation, without committing to a full inpatient stay
- Individuals needing a powerful, yet gentle supportive process to break through denial of substance abuse, behavioral addictions and/or mental health issues.
- Individuals wanting a second opinion to previous diagnosis

This comprehensive evaluation can and will help you continue your journey towards wellness no matter what your problems may be.

If you or someone you love needs **Cap** please call Cottonwood at 1-800-877-4520. There will be someone there to help you begin the life you deserve.

Quote of the Month

WHEREVER THERE IS A HUMAN BEING, THERE IS AN OPPORTUNITY FOR KINDNESS

~SENECA