

Articles

Thoughts on the Interaction of Trauma, Addiction, and Spirituality

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This article reviews the prevalence of trauma, substance use disorders, and their co-occurrence in both clinical and community populations. Deeper understanding of these phenomena is providing new and promising treatment modalities. Spiritual development and growth complement these emerging treatments.

Initially, readers may find the collection of these three topics in a single title puzzling. After all, each of these topics—trauma, addiction, and spirit—has until recently received scant, or at best intermittent, clinical and research attention and each has had a sometimes controversial history in mental health circles. However, as a practicing counselor and counselor educator, I have been living professionally and personally at the intersection of these three elements for several years now, and I continue to find the connections among them both fascinating and challenging.

At present, each of these topics is receiving renewed attention. And, it seems, the more the profession learns about the topics, the more it is coming to understand that there are intricate and vital connections among them. My hope in this article is (a) to provide some overview of recent research into these topics; (b) to share the integrated perspective that is gradually emerging for me in relation to them; and (c) to make a case for interweaving these topics into a comprehensive whole, a single tapestry.

Trauma and addiction are pervasive experiences in our society. Most people have dealt with them either directly or indirectly and have been affected by them significantly. Trauma and addiction also tend to co-occur, not just in clinical populations but also in the community. The experience and lifestyle of active addiction is, in and of itself, traumatizing and lays each struggling person open to a variety of additional traumas, including interpersonal violence, accidental injury, and the like. Traumatic experiences often engender long-term pain, an inability to cope with the pain effectively, and vulnerability to retraumatization. Substance use can often be the preferred choice of trauma victims as a kind of “self-medication” and as a means of exerting some measure of control over intolerable feelings and intrusive thoughts (Khantzian, 1999; Khantzian & Albanese, 2008). This suggests that understanding the connections between trauma and addiction is a critical task.

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[AU2] One emerging perspective is the understanding that the wounds inflicted by addiction and trauma may open up a privileged path to healing, recovery, and transformation. Trauma and addiction can be avenues of opportunity; perhaps, they have always been, as the experience of shamans and indigenous healers, mystics, and saints can attest (Grant, 1996, 1999; Smith, 2004). The path from being a person who has been victimized to one who is surviving, and even thriving (Bryant-Davis, 2005; Hartman & Zimberoff, 2005), is often a road of recovery in which the person, with the help of others, becomes "strong at the broken places" (Lazarus & Wunderlich, 1998; Sanford, 1992). It is the path of spirit and deep nourishment of the soul. I begin as follows with an examination of trauma and addiction.

Brother and Sister Maladies

Trauma and addiction share a kind of family resemblance with similar characteristics, frequent co-occurrence, and a powerful mutual toxicity that challenges standard treatment delivery. They have been called "brother and sister" (Grant, 2008, p. 5) maladies. Lifelong healing may require similar approaches.

Trauma

Trauma is the experience, threat, or witnessing of physical harm and the associated helplessness, fear, or horror attached to that experience, which is more common than sometimes believed (American Psychiatric Association [APA], 1994; Najavits, 2007; Ouimette & Brown, 2003). Trauma is associated with a variety of experiences including combat, life-threatening illness, natural disasters, physical or sexual abuse (child or adult), rape, terrorist attacks, to name only a few. Since the 1980s, people have come to understand the pervasiveness worldwide of these experiences in people's lives (Hien, 2004).

Post-traumatic stress disorder (PTSD) is a clinical syndrome of symptoms that can result from traumatic experiences. Symptoms include *intrusion* (flashbacks or nightmares, reliving of the experience), *avoidance* (avoiding conversations or recollections of the experience, detachment or limited range of affect), and *arousal* (hyper-vigilance, irritability, intense startle response), and these experiences occur over a period of time (several months or more). These and similar symptoms characterize the full psychiatric diagnosis of PTSD in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; APA, 1994, pp. 424–429).

Most people in the United States experience some form of trauma with lifetime prevalence approaching 60% for men and 50% for women (Breslau, 2009; Najavits, 2007). A 1998 study using *DSM-IV* criteria found the actual exposure to a qualifying trauma event to be closer to 89% (Ouimette & Brown, 2003). Many people, however, are believed to experience a variety of subclinical symptoms that do not rise to full diagnostic severity. It is estimated that 20% to 30% of those who experience trauma develop the

full clinical picture of PTSD symptoms (listed earlier) following the event (Najavits, 2007); the number of those experiencing less severe yet challenging symptoms is unknown.

Addiction

Substance use disorders (SUDs), including both substance abuse and substance dependence (or addiction), refer to a collection of physical, cognitive, affective, and behavioral symptoms and patterns that result in a variety of negative consequences and continued engagement in chemical use despite these consequences (APA, 1994, pp. 176–183). Some compulsive behaviors, such as pathological gambling, may also be viewed in an addiction framework (APA, 1994, pp. 615–618). Both impairment of personal, social, or work functioning (substance abuse) and experiences of physical and psychosocial deficits as well as issues of control over use (substance dependence) fit together with the recurrent and destructive consequences to form the diagnostic criteria for SUD.

Comorbidity

It is important to note that, although SUDs have wide prevalence within the general population, the estimates of co-occurring SUDs along with trauma and PTSD are quite alarming (Hutton, 2007). Among those persons who develop PTSD, 52% of men (28% of women) are estimated to develop an alcohol use disorder as well, whereas 35% men (27% of women) develop a drug use disorder (Najavits, 2007). Moreover, even higher rates of comorbidity have been documented both in clinical settings and among those with particular lifestyle vulnerabilities, such as veterans, prisoners, victims of domestic violence, “first responders” (police, firemen), and so forth (Najavits, 2004a, 2004b, 2007).

[AU3] Overall, those with PTSD are estimated to be at 3 to 4 times greater risk for developing SUDs than those without PTSD (Chilcoat & Menard, 2003; Khantzian, 2008). In addition, those with PTSD and an SUD tend to have earlier histories with alcohol and drugs, more severe use, and poor treatment adherence (Khantzian, 2008). “PTSD renders substance abuse patients more vulnerable to poorer short- and long-term treatment outcomes” (Ouimette, Moos, & Brown, 2003, p. 92). Emerging data confirm the clinical impressions of many that the existence of trauma histories as well as criteria for PTSD heighten the likelihood of addiction relapse, and multiple relapses are very often associated with a history of trauma (Norman, Tate, Anderson, & Brown, 2007). Likewise, 20% to 33% of those (men and women, respectively) with SUDs have been estimated to meet criteria for current PTSD (Ouimette et al., 2003). In recent data reported online (Miele, 2004), large percentages of female patients with SUDs and women with SUDs in community and clinical samples (25%–55%) report a history of trauma (up to 90%) or meet criteria for PTSD.

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Particularly challenging is the emerging research pointing to widespread development of SUDs among adolescents as well as earlier ages of onset. This

research goes hand in hand with data that suggest adolescents as a group are at risk for most kinds of qualifying trauma under the *DSM-IV* criteria. Recent reviews of research suggest that “adolescents are especially vulnerable for experiencing traumas involving interpersonal violence . . . [the] types of traumas that are most frequently linked to PTSD in both adolescents and adults” (Giaconia, Reinherz, Paradis, & Stashwick, 2003, p. 229). It is not surprising that studies find that large numbers of adolescents with SUDs also have trauma histories (50%–75%), have developed PTSD (11%–47%), or are struggling with both (Giaconia et al., 2003, p. 231). Ongoing work with both community and clinical populations of adolescents are “consistent with community studies of adults that have documented substantial comorbidity of SUD and PTSD in the general population” (Giaconia et al., 2003, p. 231).

Given the mounting evidence, trauma and addiction have recently been described as “brother and sister” maladies (Grant, 2008, p. 5). They co-occur often, and many times set the stage for one another. Practitioners are coming to expect one when discovering the other (Grant, 2008). And yet, this has not always been the case.

Trauma and addiction are perhaps the two most underdiagnosed and misdiagnosed conditions counseling practitioners face (Davidson, 2001; Najavits, 2004b). Despite clear evidence of high rates of trauma and SUDs in a variety of at-risk populations, there has been “systemic neglect” (or systemic denial?) of both conditions (Jacobsen, Southwick, & Kosten, 2001; Najavits, 2004b, p. 2). Both were latecomers to acceptance within mental health terminology, and consequently have experienced a “marked separation” into separate and distinct fields of practice (“silos”) with different and often competing funding streams (Miller, 2002; Najavits, 2007, p. 142). Practitioners on either side of the split have been unable to diagnose the other condition in their own clients; systems have been built to treat one or the other disorder, but not both (Hutton, 2007). As a result, those with the dual diagnosis of comorbid trauma (or PTSD) and SUDs often experience a treatment system unable to cope with their needs (Anda, 2008; Ouimette et al., 2003) and therefore evidence “worse outcomes than those with either disorder alone, higher rates of subsequent trauma, and a more severe clinical profile” (Najavits, 2004a, p. 467; Ouimette, Finney, & Moos, 1999).

Miller (2002) has described the “deadly logic” at work underneath addictions, trauma, and a variety of mental health concerns, which form a “toxic feedback loop” (p. 158). The ongoing stress of unaddressed trauma becomes the catalyst for many mental health symptoms, which stimulate the drive to abuse and addictive (SUD) behaviors. The consequences of these behaviors increase stress, exacerbate mental health conditions, and heighten vulnerability to renewed trauma and recurrent substance use. Khantzian (1985, 1991, 1997; Khantzian & Albanese, 2008) described in detail over many years the resort to SUDs as “self-medication,” addressing human suffering, deficits in self-care, and the need to manage painful or overwhelming feelings and thoughts. New information is helping counseling practitioners to understand these interconnections even more starkly.

Adverse Childhood Experiences (ACE) Study

When a child is wounded, the pain and negative long-term effects reverberate as an echo of the lives of people they grew up with—and then they grow up, at risk for taking on similar characteristics and behaviors—thereby sustaining the cycle of abuse, neglect, violence, substance abuse, and mental illness. (Anda, 2008, p. 16)

[AU6] Today, we may be witnessing the confluence of biobehavioral (Leshner, 1997, 1999; National Institute on Drug Abuse, 2007), biopsychosocial (Donovan, 1988; Kumpfer, Trunnell, & Whiteside, 1990), and psychological (e.g., “self-medication”) models through deeper understanding of trauma and addiction. One topic being explored is the linkage between addictions of all kinds and experiences of childhood and/or adult trauma (Evans & Sullivan, 1995; Grant, 1994, 1996; Miller, 2002; Najavits, 2003, 2004a, 2004b, 2007). This was the focus of a recent 2007 conference sponsored by the National Center on Addiction and Substance Abuse at Columbia University, titled *Compound Fractures: Substance Abuse and Trauma*.

[AU7] Studies from the Centers for Disease Control and Prevention (2009), in collaboration with the Kaiser Permanente Department of Preventive Medicine in San Diego, California, have pursued the connections between childhood trauma and a host of negative and costly health-related conditions, including SUDs. These studies of *adverse childhood experiences* (ACEs), and their consequences in adulthood, are quite troubling. Yet, they can help to shed light on the connections and potential pathways between trauma and addiction. (For more extensive and detailed information on the studies, their design, and their findings, see Centers for Disease Control and Prevention [2009].)

ACEs are understood to be trauma exposures that constitute a frequent and “common pathway” to “social, emotional, and cognitive impairments that lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability and premature mortality as people age and develop” (Anda, 2008, p. 3). ACEs are considered the “hidden engine” underneath many of the nation’s leading health and social problems, including SUDs.

Similar to the work of Breslau (2009) and others, the ACE studies represent a broadening of our understanding of traumatic experiences. For their research, the ongoing ACE study—one of the largest and most comprehensive studies of its kind—assessed (a) the prevalence and impact of 10 categories of stressful and traumatic childhood experiences in a large population of Americans (> 17,000) and (b) the relationships of these experiences to a variety of later health and social consequences (Anda, 2008). Their findings confirm that risks are neither evenly nor randomly distributed over the population but rather tend to occur in clusters; those who experience trauma tend to experience more than one kind and, in fact, receive multiple “doses.” For example, 81% of those who grew up with household substance abuse reported at least one (and often more) additional ACEs (Anda, 2008). The relevant childhood stressors are interrelated, often co-occurring in the same homes and increasing the “dose” of trauma to family members.

The ACE categories of traumatic experiences include such things as growing up abused or neglected, witnessing parental marital discord or domestic violence, or living with household members who are substance abusing, mentally ill, or a criminal. The effects of these experiences are seen to be powerful, long term, and cumulative. "The experiences of childhood—specifically stressful or traumatic experiences that can negatively affect childhood development—are fundamental and often 'hidden' underpinnings of the occurrence of multiple health and social problems" (Anda, 2008, p. 4) over a lifetime.

ACEs have a profound and lasting impact many years later, although they are transformed from psychosocial experiences into organic disease, poor social functioning, mental illness, and addiction (Anda, 2008).

More important, the ACE investigators have begun to document evidence of an association between these social and environmental experiences and the process of neurodevelopment. This is understood as a mediating factor in the vulnerability for addiction (Anda, 2008; Felitti, 2003/2004). "Stressful and traumatic childhood and adolescent experiences literally become 'biology' affecting brain structure and function (as well as endocrine, immune, and other biologic functions) thus leading to persistent effects" (Anda, 2008, p. 14). This is one more piece of the puzzle implicating childhood maltreatment to long-term changes in brain structure, function, and long-term responses to stress (Bremner & Vermetten, 2001; DeBellis & Thomas, 2003). The cumulative impact on physiological stress-responsive systems is extensive and far reaching and may help to explain some of the adaptive and destructive features of addiction (Khantzian & Albanese, 2008).

Adverse childhood experiences have been found to have a "particularly strong association with alcohol abuse" (Anda, 2008, p. 9) and in fact account for a large portion of risk for adult alcohol abuse regardless of parental alcoholism. It is not surprising that Felitti (2003/2004) and the other ACE researchers (see Felitti et al., 1998) have demonstrated the relationships between ACEs and smoking (250% increased risk over children without ACEs), alcoholism (500% increase in self-acknowledged alcoholism), and injection drug abuse (46-fold increased risk). According to Felitti (2003/2004),

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Our findings indicate that the major factor underlying addiction is adverse childhood experiences that have not healed with time and that are overwhelmingly concealed from awareness by shame, secrecy, and social taboo. . . . The ACE Study provides population-based clinical evidence that unrecognized adverse childhood experiences are a major, if not the major, determinant of who turns to psychoactive materials and becomes "addicted." (p. 8)

Spirituality: Way of the Wound

You see, alcohol in Latin is "spiritus" and you use the same word for the highest religious experience as well as the most depraving poison. The helpful formula therefore is: *spiritus contra spiritum*.—C. G. Jung

[AU9]

Trauma survivors seem to find in the spiritual an additional possibility of hope and meaning. (Decker, 1995, p. 2)

Understanding the pervasiveness and co-occurrence of trauma and SUDs can be both daunting and dispiriting. Hope, however, can come in many forms. Currently, for example, there are a number of emerging, evidence-based, and effective assessment and treatment modalities for both conditions

[AU10] (Carruth, 2006; Najavits, 2003, 2005, 2007; Najavits, Schmitz, Gotthardt, & Weiss, 2005; Ouimette & Brown, 2003).

An observation often reported in the literature views trauma injuries as potential opportunities for deeper personal growth and transformation (Burke, 2006; Denton, 2009; Grant, 1996, 1999; Herman, 1992; Miller, 2002; Smith, 2004; Tick, 2005). Robert Grant (1996) described this phenomenon as

[AU11] “the way of the wound,” that is, trauma as a path to a deeper Self. This is familiar language to those in addiction studies and 12-step recovery.

Elsewhere, I have described the connections between spirituality—the cognitive, affective, and behavioral dimensions of a search for meaning, connections, hope, and the sacred—and recovery from addictions (Morgan, 1995, 2007; Morgan & Jordan, 1999). Recovery is a path of transformation; it allows one to acknowledge and live from deeper aspects of life and awaken to the call of spirit or a higher power. The recovery from trauma is similar and seems to share a family resemblance here as well (Grant, 1996). Just as with addiction there are many recovery paths—personal enlightenment, sudden transformations, the path of service, advocacy, compassion, healing others—so too in trauma recovery, a variety of paths open up (Grant, 1996; Herman, 1992). Underneath these avenues of healing and recovery, however, is a common element of spiritual growth and development for persons who have been wounded. Addiction and/or trauma can set one’s feet on the path (Miller, 2002).

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As with addiction, there is a “dark power” to trauma that sometimes functions like a god, transcending and breaking through current worldviews and imperiously drawing attention and obsession (Grant, 1996, 1999; Jordan, 1995; Smith, 2004). It is the power of deconstruction (Grant, 1999).

Grant (1996, 1999) and others have described trauma’s threefold, deconstructive power. First, trauma presents an “*existential challenge*,” starkly demonstrating that “the world is neither safe nor predictable” (Decker, 1995, p. 3) and challenging one’s “fundamental assumptions about meaningfulness, goodness, and safety” (Drescher & Foy, 2005, p. 4; Tobin, 2005).

[AU13] It engenders a crisis of faith (Burke, 2006). Also, the experience of trauma is a catalyst for a crisis of meaning, of hope. It unmasks our taken-for-granted beliefs and frames of reference (Denton, 2009) and reveals fate’s indifference or previously unsuspected depths of human malice (Mahedy, 2005, p. 6).

[AU14] Trauma challenges our beliefs in fairness, kindness, grace, love of neighbor, forgiveness and redemption as core values for living (Mahedy, 1995; Smith, 2005). It often leaves those who have been victimized hopeless, despairing, and alone. Finally, trauma shatters the ego, placing tragedy, not love, at the center of one’s personal narrative, revealing the shallowness of one’s all-too-frequently socially constructed personae, and thrusting the individual on deeper resources for survival (Grant, 1996, 1999).

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As with recovery from addictions, trauma recovery involves repair of connections to community and restoration of shattered trust. Significantly, recovery from both addictions and trauma require the restoration of hope (Burke, 2006; Yahane & Miller, 1999) and a renewed sense of motivation and purpose (Martin & Booth, 1999). Restoring a sense of meaning, renewing relationships, and “creating a reverence for life coupled with a sense of social purpose” (Miller, 2002, p. 169) are also critical (Herman, 1992).

Faith (a sense of trust and meaning), hope (resilience in the face of despair), and love (renewed connections and community) are the three great spiritual virtues. These virtues are critical elements in a spiritually sensitive focus in clinical care and nowhere more critically than in addiction and trauma recovery (Burke, 2006; Morgan, 2007). It remains for compassionate practitioners to learn how to be catalysts for faith, holders of hope, and bearers of love.

It is beyond the scope of this article to describe the array of spiritual attitudes, skills, and practices that might be involved in spiritually sensitive treatment of addiction and trauma. The interested reader may wish to consult several other sources for more information in this area (Burke, 2006; Drescher & Foy, 1995; Morgan, 2007; Smith, 2004; Tobin, 2005). It is, however, important to remind readers that exploration of one’s own spiritual beliefs, worldview, practices, and attitudes toward such values as faith/trust, hope, forgiveness, and love is a critical task—not to mention the task of exploring one’s own substance use and potential traumas—for any counselor who wishes to be a guide on the journey of recovery (Grant, 1996; Morgan, 2007).

Summary

I have tried to convey a sense of the prevalence of trauma experience, substance misuse and addictions, and the co-occurrence of the two in this article. I have also tried to suggest that these phenomena call counseling professionals to a deeper understanding of the potential interconnections among them, and to a consideration of the potential means for treatment, healing, and recovery for persons affected by them. Increasingly, it seems, the realm of spiritual healing and development may be a useful complement to emerging programs and technologies for treatment. This can be the path of healing and much, much more. I am reminded of a line from Hemingway that says it well:

[AU16] The world breaks every one and afterward many are strong at the broken places.
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