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S I E R R A T U C S O N

P R O G R E S S

Exploring Trauma, Addiction & Recovery from a Depth-Psychological Perspective

By Johanna O’Flaherty, Ph.D., CASC, NCACIII, CEAP

It is recognized that up to 50% of adults and 80% of adolescents diagnosed with a substance abuse disorder have at least one other psychiatric disorder. In addition to assessing patients for comorbid issues (including trauma) during the initial Intake phase, Sierra Tucson’s treatment team incorporates a trauma history for every patient in the early stages of treatment, and they are continuously assessed during their stay. Consequently, there are times when patients are referred directly to one of our specialty programs, e.g., for healing from trauma. It is important to illuminate, however, that our philosophical approach to treatment is holistic—encompassing body, mind, and spirit. Therapists employ a multi-varied psychological approach together with an overriding depth-psychological approach.

Depth psychology is considered the psychology of the psyche and claims to furnish a key to the exploration of the unconscious mind. Many techniques such as dream analysis, imagery, writing, body movement, free association, the use of sand tray therapy, along with various kinds of tests, stimulus words, etc., are used to access the unconscious. Broadly speaking, depth psychology operates according to the following working assumptions. The psyche is a process—a verb rather than a noun—that is partly conscious and unconscious. The unconscious contains repressed experiences and other personal-level issues in its “upper” layers and “transpersonal” (i.e., collective, archetypal) forces in its depths. The psyche spontaneously generates mythical-religious symbolism and is, therefore, spiritual as well as instinctive in nature. Perhaps the value of a depth-psychological approach is not in how much we know or learn about the unconscious but, rather, in the fact that the unconscious knows so much about us.

Correlation Between Trauma & Addictions

The correlation between trauma and addictions is astounding. Over the years, I have come to understand that individuals treated for alcoholism and other substance abuse dependency need to be evaluated for trauma. A trauma history needs to be taken in the early stages of treatment, as unresolved trauma will stymie recovery and lead to relapse. In many ways, the mood-altering substance was used to anesthetize the psychic pain of the traumatized individual. When the substance is removed, the trauma is exposed, and, invariably, the individual becomes emotionally flooded. Essentially, the clinician should incorporate a trauma evaluation into the psychosocial history.

In *Secondary Traumatic Stress*, Stamm (1995) recommends that a trauma history be included in all psychosocial histories, and that the clinician secure some type of trauma history from all patients who present for help with a physical or psychological problem.

I’ve had the privilege of working with many persons in long-term recovery who sought psychotherapy to heal their trauma. Clients sought treatment to address family-of-origin trauma, sexual trauma, the trauma of ancestral shame, and self-inflicted trauma through the use and abuse of mood-altering substances. Recovering individuals who have experienced a traumatic event need specific compassion and understanding from their clinician. The most appropriate clinicians to serve this particular population are clinicians who have an understanding of Twelve-Step programs and the complexities of addictions. Historically, we were under the illusion that *all* we needed for recovery was not to drink and to attend Twelve-Step meetings. While I am a strong supporter of the Twelve Steps’ spiritual principles and philosophy, AA literature supports that individuals need to seek outside professional help for psychological issues. Applying depth psychology incorporates the use of metaphor; for instance, the individual’s behavior may be a metaphor for unresolved trauma. Often, the client is acting out the trauma story, as s/he is unable to find words to describe the trauma. In order to begin a healing process, the trauma story must be told. Otherwise, the psyche will compensate and find alternative ways of expressing itself.

The Evolving Understanding of Trauma & Addictions

One of the most prevalent themes that has emerged in theoretical treatments of trauma is the notion that the human psyche, in encountering and attempting to process a traumatic event, undergoes some sort of disconnection. This type of sudden and complete split

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from one's normal mental faculties is a response that helping professionals who work with traumatized individuals are prepared to encounter. As one might expect, multiple or chronic trauma experiences are likely to be more difficult to overcome than most single traumatic instances. In other words, risk for Post-Traumatic Stress Disorder (PTSD) increases with each new exposure to trauma. Individual differences certainly play a role. For example, more introverted or shy individuals may have stronger emotional reactions to upsetting events; and young children will have less ability to predict, avoid, or make sense of such experiences.

Emotional Memories are Forever

"A traumatic event is not pushed out of awareness; rather it is too big to register awareness. Traumata only return from repression when a sufficient inventory of comparable events provides a reality schema that can more or less absorb them." (Morgenson, 1992)

Traumatic emotional memories are stored on a cellular level, and recalling them usually includes a visceral response. For instance, we can ask anyone in the United States where they were on September 11, 2001, and they will be able to recall verbatim their exact location, memories of the event, and the visceral responses they experienced when hearing about the terrorist attacks. One's ability to recall vivid memories of a traumatic event substantiates that, indeed, emotional memories are imprinted in our psyches. It is conceivable that traumatic memories could emerge, not in the distorted fashion of ordinary recall, but as affective states, somatic sensations, or as visual images. These experiences may be the result of decreased

inhibitory control that occurs under a variety of circumstances, such as influence of drugs and alcohol, during sleep (as nightmares), with aging, and after exposure to strong reminders of the traumatic past.

Comorbidity: Trauma, Substance Abuse & Other Psychiatric Issues

Depression and adjustment disorders (anxiety and depression) may be relatively common in the 6-12 months after a traumatic incident. Research has shown that major depression and substance abuse (drugs, alcohol, and tobacco) are frequently comorbid with PTSD. Other symptoms and psychosocial problems may warrant psychiatric attention and intervention. Reckless financial behavior may also be a symptom of unresolved trauma.

Assessing the Psychological Complexities of Trauma

PTSD is the most common diagnostic category used to describe symptoms arising from emotionally traumatic experiences. This disorder presumes that the person experienced a traumatic event involving actual or threatened death or injury to themselves or others—where they felt fear, helplessness, or horror. Three additional symptoms, if they persist more than a month after the traumatic event and cause clinically significant distress or impairment, make up the diagnostic criteria:

- Intrusions, such as flashbacks or nightmares, where the traumatic event is re-experienced.
- Avoidance, when the person tries to reduce exposure to people or things that might bring on their intrusive symptoms.
- Hyperarousal, meaning physiologic signs of increased arousal, such as hypervigilance or increased startle response.

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Letter from the Executive Director David E. Anderson, Ph.D.

Dear Friend,

What is the difference between 91 and 95? Not much, but....

I remember a story I once heard about a little boy and his father who were walking along a beach. A few hours earlier, a severe ocean storm had washed thousands and thousands of little sea creatures up on the shore. Many of the critters were trying desperately to get back to the safe harbor of the ocean, but most were perishing. Suddenly, the little boy began picking up handfuls of the little unfortunates and throwing a good many of them back into the sea. His father watched with amusement and then finally asked his son, "Why are you doing that? There are thousands and thousands of them. It just doesn't make any difference to throw some of them back into the water." His son picked up a half-dried-out but still living starfish, threw it far into the ocean and said, "But you see, Dad, it makes all the difference to that one."

So if I tell you that we've just completed construction on two new patient rooms, which now allows us to increase our patient count from 91 up to 95 patients, I imagine most of us (self included) would probably yawn and say something to the effect of, "Well, that's nice, but pretty boring information."

But, of course, those extra four beds make all the difference to those folks who we might have had to turn away before. As most of us in this wonderful field of Recovery and Discovery know, the opportunity to come to a place like Sierra Tucson is quite often and quite literally a matter of life and death. We're glad to now be able to make a difference in more lives.

I'm also happy to report to you that we are in the midst of some rather extensive remodeling and renovation projects. We're adding new offices and new group rooms; we're expanding the dining room area; we're recarpeting much of the facility; we're doing some new landscaping; we're committed to keeping our buildings and grounds amongst the finest and most beautiful in the country. If it's been awhile since you've been on campus, I invite you to come see our face-lift!



But more than anything, I invite you to celebrate with us the difference between 91 and 95.

Sincerely,

David E. Anderson, Ph.D.

David E. Anderson, Ph.D.
Executive Director

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Psychological Interventions & Treatment Implications for Trauma

The traumatized person, by definition, has experienced an event that is so unusual that the person's normal coping ability is compromised. Although the thoughts and feelings the client is experiencing may be painful, perplexing, and not well understood by individuals and professionals unfamiliar with these reactions, the client must be assured that their experiences are normal reactions to abnormal situations. To assist traumatized clients, we must mobilize their coping skills and validate their experiences. This psychotherapeutic modality is *quite different* from most traditional psychoanalytic modalities, where the premise is that symptoms are basic personality flaws and neurotic defenses to be treated according to traditional paradigms.

Although a vast majority of counseling professionals view the process of trauma treatment through a cognitive or psychodynamic perspective, I believe that a holistic approach must be considered to help the individual heal and integrate the experience of trauma. Therefore, treatment implications are explored from a psychophysiological, psychological, and spiritual perspective.

The core principles to trauma therapy include the normalization principle, the re-experiencing principle, and the individuality principle. PTSD may mimic personality and anxiety disorders. It may precipitate physical and psychiatric conditions. It may exacerbate preexisting disorders. It may be confounded by coexisting problems, including normal stages of life adjustment (Wilson, 1988).

The therapist creates a healing environment to facilitate as a witness and supporter in whose presence the victim can re-tell the harsh realities of the trauma. A depth-psychological approach to healing trauma is more appropriate than the more directed therapies, as traumatized individuals must be allowed to keep their "defenses" until they are ready to share. Healing is the patient's journey, and we are well advised "not to rush the river."

The Role of Spirituality in Healing

Mythology and, indeed, all the great religions of the world are preoccupied with the relationship between the human and the divine and how it is maintained in the face of human suffering. Through suffering, man's soul usually reaches out to the spiritual through prayer. The power of prayer in surviving suffering is well known. Traumatized individuals have experienced an earthquake of the soul; therefore, as well as psychological counseling, spiritual assistance is necessary. Traditionally, the priest, poet, or shaman (and more recently the clinician/caregiver) acted as symbolic carriers of the transcendent function of the unconscious. Frequently,

spirituality is conceptualized as an awareness of a "Higher Power's" love and is often described as a transcendent feeling of harmony and communion with humanity or nature.

Merwin and Smith-Kurtz (1988) state, "Spirituality is a state of being fully alive and open to the moment. It includes a sense of belonging and of having a place in the universe." A sense of belonging is very evident everyday in the rooms of Alcoholics Anonymous and other Twelve-Step programs. Although spiritual growth is a type of healing from which most of us could benefit, a victim's sense of spirit may be acutely dimmed for a period after traumatic incident(s). Over time, however, as the person heals, the potential for spiritual growth may become greater than before—even greater than those who have not faced the darkness of trauma. Obviously, the clinician's role is not to promote any specific spiritual approach; rather, it is to provide a bridge to assist with the transcendent function of the ego processing.

Summary

Traumatic experiences have an overwhelming impact on the individual, affecting the victim emotionally, psychologically, physically, spiritually, and socially. Treatment must encompass a holistic approach focusing on body, mind, and spirit with complete restoration of health to the whole person. Depth psychology and cognitive/behavioral techniques can be used in a complementary fashion when treating trauma and addiction. Treatment methods geared toward improving the health of the patient must clearly be multidimensional in both scope and approach, as emotional, psychological, physical, and spiritual development are all essential to the health and well-being of the individual. The client suffering from trauma and addiction needs to realize that he or she is not alone.

By **Johanna O'Flaherty, Ph.D., CASC, NCACIII, CEAP**

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*Meet Johanna O’Flaherty, Ph.D., CASC, NCACII, CEAP
 Clinical Program Director*

For the past 25 years, Dr. O’Flaherty has been a catalyst for healing through many traumatic situations. She sees her involvement in the aftermath of disasters such as 9/11 in New York and TWA’s Flight 800 near Long Island as “life-changing experiences—because I have been allowed to be there and help in a small way with people who have experienced an earthquake of the soul.”

As a Certified Trainer for Critical Incident Stress Debriefing Programs, Dr. O’Flaherty has developed and implemented Crisis Response Programs and Teams for several airlines in many countries, as well as Critical Incident Response training for the FBI and law enforcement officers. She served on a focus group with the Airline Transport Association to develop industry guidelines for Crisis Response Teams and, after 9/11, assisted with the counseling of airline employees and facilitated Crisis Response training for the New York City Transit Authority. Dr. O’Flaherty conducts holistic workshops in Asia, Europe, the Middle East, and the U.S.A, which are always didactic, experiential, and inspirational. For over 20 years, Dr. O’Flaherty developed and managed Airline Employee Assistance Programs. She holds a doctorate degree in Clinical Psychology from Pacifica Graduate Institute, California. She is a Nationally Certified Addiction Specialist (Advanced Level) and a Certified Employee Assistance Professional (CEAP); she has been featured on ABC, NBC, MSNBC, and CNN.

Dr. O’Flaherty grew up in a large Irish family and adores her many nieces and nephews. As a young woman, she adopted the U.S. as her home. She has traveled the world and is grateful for her multicultural background.

Having begun her own healing journey 28 years ago, Dr. O’Flaherty made a commitment to be part of the solution and facilitate healing from grief, trauma, and addiction. Her goal in life is to stay centered spiritually, emotionally, and physically. “As my Irish mother would say,” recalls Dr. O’Flaherty, “If you don’t take care of yourself, you’re no good to God, man, or country!”

In November 2005, Dr. O’Flaherty became Sierra Tucson’s Clinical Program Director. Although challenged by a hectic schedule, she practices a spirituality of simplicity and compassion for self and



others—and being present in the moment. “Sierra Tucson complements my commitment through its philosophy; talented, skilled, and experienced clinicians; and patients. The staff and patients are a circle, and there is no hierarchy from my perspective. The staff have begun their healing journey, and now we are honoring the patients by walking beside them.”