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Finding the Cure: The Appropriate Therapeutic Approach for Self-Medication to Cope with Co-occurring Disorders

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Abstract

This article outlines the influence of sexual trauma on the use, abuse and dependence of substances for the desired outcome of self-medication. Clinicians will be presented with the use of Dynamic Systems Theory to explore internal and external systems of clients struggling with a co-occurring disorder of sexual trauma and use of alcohol and/or drugs. The utilization of a systems theory model and understanding the multifaceted impact of a traumatic incident will further expand trauma-informed therapeutic interventions and harbour a safe and stable environment for assisting within the exploratory healing process of client experiences. This article offers a literature review of Substance Use Disorders (SUDS) along with clarification of sexual trauma, followed by a clinical vignette supporting this approach.

Keywords: Co-occurring disorder; Self-medication; Sexual trauma; Dynamic systems theory

Introduction

Exploring increasing rates of substance use caused by past sexual trauma that had not appropriately been processed by a victim, is critical to the care and security therapists provide to clients. The advanced understanding of how Substance Use Disorders and traumatic experiences affect a person's ability to function in society is fundamental to serving the unique needs of this stigmatized population. Therapists, clinicians, counsellors and medical practitioners interact with these critical issues on a daily basis and are in need of a better understanding of the underlying issues and internal dissonance co-occurring diagnosed persons experience on a daily basis.

Review of Literature

Co-occurring Disorders (COD) are defined as the simultaneous prevalence of a mental health disorder and a substance use disorders(s) [1]. Recent data shows that over eight million adults within the United States of America are affected [1]. Manuel, Stebbins & Wu discuss within their study of gender differences, the perceived unmet treatment among COD including, distinct patterns of unfulfilled therapeutic interventions, which leaves clients vulnerable and high-risk [1]. The study further exemplifies a need of specific, appropriate care for individuals diagnosed with COD as 45% to 60% of adults with a Substance Use Disorder congruently have a mental health disorder. In conjunction, counterparts with mental health disorders, between 20 and 50%, are also diagnosed with a Substance Use Disorder [1]. This is evidence that the risk of self-medication is prevalent among the mental health population.

Self-medication is a form of self-destruction, a behavior that encompasses use of one or more substance, prescription or recreational, without the therapeutic monitoring of a physician [2]. In a study presented in 2018, researchers found that the destructive act of using mood-altering chemicals without the consent or advisory of a medical professional is prevalent throughout multiple populations including pregnant women, teenagers, individuals who struggle with mental health [1]. Self-medication is the desire and continuous attempt to self-administer emotional, psychological and physiological pain, in the efforts to gain pleasure or at the least mood-modification, through the use of unhealthy compulsive behaviors [2]. Dr. Dayton explores how self-medicating is a representation of a lack in self-regulation due to an absence of emotional sobriety from compulsive behaviors to assist in attaining a numbing response [3]. Odenbring shares, drugs and alcohol meet the needs of vulnerable individuals, one who engages in compulsive and often unhealthy behaviors, thoughts or impulses. The goal of self-medicating is to feel as if they have regained impediment on their own bodily control, incure obstruction of personal thought processes or avoid awareness of emotional neglect. The strong desire to find an escape from a memory coupled with a hyper-focused processing style with the function of masking or managing inner-pain is what makes self-medicating appealing [3].

Edward J. Khantzian, a professor of psychiatry at Harvard Medical School and founder of our Department of Psychiatry, initiate research on the correlation between the desire to cope with painful effective states and substance use [4]. Khantzian found the correlating between the two behaviors with little variation, thus he established the Self-Medication Theory. The desire to cope with unwanted effective stated, transforms it to self-destructive behaviors, which take numerous forms such as substance abuse, eating disorders, self-mutilation, suicidal ideations, plans, thoughts, attempts, and also repetitive involvement in exploitative or dangerous relationships [5]. From Dr. Bessel Van der Kolk's book The Body the Keeps Score, he emphasizes ways personal experiences have the capacity to result in somatic symptoms, which can be physically painful [6]. Dayton expands research on how the practice of self-medication is the evasion of pain and avoiding psychosomatic experiences to therefore feel something other than hurt [3]. Psychiatric illnesses of any kind, minor or acute, have the impact of inflicting painful states affiliated with struggles of self-regulating emotions, self-esteem, relationships and self-care.

The connection between COD and self-medication rises the concern regarding how and where individuals struggling, seek aid to develop skills for coping. A study published in April 2018 developed to identify the impact agencies play in the continuing care of treatment for Substance Use Disorders and Co-occurring Disorders, exploited the decrease in desire for engagement in outpatient services by clients diagnosed with COD [7]. Lee et al. found within their study, individuals identified with COD were less likely to engage in treatment, specifically at the outpatient level of care, compared to their counterparts who were diagnosed solitarily with SUDs [7]. From the 7.7 million adults across the United States surveyed in 2017 diagnosed with COD, 52.5 per cent denied past or present engagement in treatment regardless of the level of care [8]. Additionally, the lack of outreach for care was considered to be congruent with the perceived lack of need for services asking as a barrier to enrollment in treatment [8].

Substance Use Disorders

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is utilized in the diagnoses process of mental health and Substance Use Disorders. The DSM-5 describes, the essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. There are ten separate classes of drugs identified within the DSM-5, which include: alcohol (beer, wine, liquor), caffeine (coffee or pills), cannabis (marijuana), hallucinogens (LSD, MDMA), inhalants (Nitrous), opioids (Oxycontin, heroin), sedatives (hypnotics, anxiolytics), stimulants (amphetamines, cocaine), tobacco (chew and smoke) and substance-related or other addictive disorders/behaviors.

In addition to identifying the class of substance an individual may be using, medical and mental health professionals utilize the DSM-5 to determine severity of substance use when building a clinical summary of client struggles [9]. The criteria used is the relevance and quantity of symptomology presented by the individual [9]. The diagnosis of a substance use disorder is determined through pathological patterns in behavior directly correlated to the use of a substance(s). Use is classified as "mild" when there is a presence of two to three symptoms, "moderate" with a presence of four to five symptoms and considered to be "severe" when six or more symptoms are present at one time [9].

The Substance Abuse and Mental Health Services Administration, also known as SAMHSA, is a combined association focused on epidemiology, research and treatment of mental health and addiction [10]. This administration defined substance use disorders as an extremely complex chronic disease, as its effects last for a period of three months or longer [10]. Creating the determining elements of this chronic illness are multiple factors such as early acquisition with late onset, individualized progression, effectiveness of oriented behavioral care, and co-morbidity [10]. This disease is not only affecting the individualized addict or alcoholic, but their family, community and society altogether as identified and outlines for potential consequences within the DSM-5 [10]. The progression of this disease can be noticed within months or years, depending on the severity of the symptoms of addiction, in which the person presents [10].

Three attributes of addiction prevail when an individual is diagnosed or identifies as a substance abuser; Genetic Predisposition, Impulsivity and Trauma [9]. Genetic predisposition reflects on the genetic composition of an individual along with familial biological factors [10]. "Addictive drugs change the brain, genetic studies show that alcoholism has a substantial heritability, and addiction is a persistent, destructive pattern of drug use," [9]. Genetic vulnerability plays a pertinent role in a person developing a dependency from recreational use of any mood-altering substance. "Were this not the case, treatment could simply consist of locking addicted people away in a protective environment until withdrawal symptoms were comfortably behind them, issuing a stern warning about future behavior, and having done with it. The research provides an understanding of how hereditary factors not only play a role for the genetic make-up of DNA creating physical characteristics, but also for addiction as well. According to research on twins and the impacts of genetic predisposition towards addiction, suggests both fraternal and identical twin pairs have shocking commonalities regarding their chemical use, abuse and dependence.

SUDs are considered to be an impulse control disorder, as determined within the DSM-5, through the remaining classification of substance-related or other addictive behaviors. Addiction is palpable when "symptoms characteristic of a disruptive, impulse-control, and conduct disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate," in which the individual is unable to function day to day [9]. Struggles with impulse control inhibits a person's functioning, therefore leading them to potentially self-medicate [9]. SAMHSA studied "a relapse rate of 5% after one year and 12% after three years," suggesting that relapse and a return to substance use is possible even after a substantial period of abstinence from all mood-altering chemicals [10]. For after years of abstinence, evidence reveals an individual historically impacted by addiction may impulsively react to an identified or unidentified trigger, therefore using a substance to alleviate an unwanted emotion [10].

Additionally, the experience of a traumatic event plays an integral role on a person's probability of developing a Substance Use Disorder [11]. Positive reinforcement of substance use equates to the inability of appropriately processing the events of a traumatic experience. Intoxication is encouraged for the purposes of self-medication to create the illusion of euphoria or numbness [3]. However, when a person endures withdrawals, they experience a negative reinforcement, which further supports the continued use of substances to avoid additional discomfort [10]. For individuals who have experienced a traumatic event, there is a higher tendency to abuse substances with tranquilizer-like qualities, such as Alcohol, Xanax, Valium or Klonopin, as these drug properties prevent worry, hypersensitivity and produce a more calming state [6]. The risk of taking medications such as these, either prescribed or obtained illegally, is the high addiction potential and risk for interrupting progression for trauma processing [6]. The role of addiction surrounding trauma is to neutralize unwanted sensory experiences and protect one's self from reliving or reacting to psychosomatic stimuli derived from witnessing distress [6].

Sexual Trauma

Sexual trauma is complex clinically and empirically due to the inclusion within classification of sexual harassment, assault and rape. The significance of recognizing ways in which an individual can processes their trauma is integral to effective therapy, especially because of the multifaceted effects it has on all areas of productive functioning [5]. Avoidance is a key factor in trauma but embracing vulnerability to avoid detachment from others is an important step in the recovery process [12]. Therefore, the role of the therapist within

the therapeutic alliance is to assist the client in completing the task of processing trauma, allowing reinstatement of power and control in life [5].

Characteristics must be cogitated prior to determining a specific definition of one's experience(s) of sexual trauma [13]. These characteristics are determined by who committed the assault along with the perpetrator's relationship to the victim to assist in specifying the incident as an acquaintance assault or a stranger sexual act [13]. The relationship between victim and offender in addition to clarifying the enacted sexual acts assist in determining the typology of behaviors as sexual assault or rape [13].

Sexual assault is broken into different classifications to include sexual coercion, sexual abuse or controlling acts and noncontact unwanted sexual experiences [14]. Bagwell-Gray, Messing and White describe sexual coercion as being forced into sexual activities through physical or verbal tactics which transition into further controlling and abusing acts (2015). Coercion is the encouragement of favors or engagements, to which the identified victim is unable or uninterested in consenting to a sexual behavior [14]. Sexual abuse consists of "unwanted sexual experiences involving touch but not sexual penetration, such as being kissed in a sexual way or having sexual body parts fondled or grabbed," [14]. Female-bodied persons sexual body parts considered to be inappropriate include the mons pubis, clitoris, labia, lips, majora/minora, breasts and anus [15]. Male-bodied persons body parts considered to be inappropriate are the penis, foreskin, lips, testicles and anus [15].

In addition to physical touch sexual assault includes noncontact unwanted sexual experiences involving, "someone exposing their sexual body parts," through flashing and/or engaging in masturbation in front of another thus making the person to be a victim of speciation [14]. Also included is forcing a victim to view or participate in photographs/films of sexually explicit materials or being harassed in public, forcing them to feel unsafe in the environment [14]. Rape is defined by "any unwanted intercourse or penetration obtained by forces, by threat of force or when a partner is unable to consent," on any orifice, oral, anal and vaginal [14]. Rapes are not only determined from penetration of a genital body part, but also digital and object penetration as well, which is the utilization of an offender's finger or an identified object inserted into an orifice of the victim [14].

Physiological and neurological functioning is impacted when an individual endures a traumatic experience [5]. Experiencing trauma impacts normal progression of psychological stability and acquiring psychological and biological fundamental development [16]. The consistent threat of potentially reliving trauma arouses the sympathetic nervous system, responsible for the fight, flight or freeze reaction, creating the feeling of adrenalin and remaining in a state of alert [6]. Trauma impacts the body's integrity, developing an automatic psychological response such as being more sensitive to noises, feeling defensive, neglected, lack of trust and results of a suffering memory [6]. The modulation of emotion is the result of the limbic system, cortex, brainstem, hypothalamus and amygdala initiating a focus on triggers, memory deformation and hypersensitivity on past experience [16]. The accumulations of all factors disembodies one's ability to self-regulate emotions, behaviors and outcomes [16].

Dynamic Systems Theory

Dynamic Systems Theory (DST) explores multiple pathways and challenges to identify intricacies of the sexually traumatic experience through the use of multiple references or resources [17]. DST further permits an understanding of internal and external stresses, experiences and views to effectively then collaboratively identify appropriate coping skills for the client who experiences a traumatic event [17]. This approach examines the individual along with relationships and interactions within the therapeutic recovery process to holistically de-stigmatize trauma and empower the client [17].

DST validates not only external systems that enable the client to function or experience dysfunction, such as family, peer supports and employment, but also their internal systems including digestive, central nervous, emotional functioning, etc., [17]. It is integral for therapists to identify both internal and external systems when working with a client who has experienced trauma and is utilizing substances for self-medication [17]. As Keenan explains, a person will experience psychosomatic phenomena's when processing trauma similar to that description from Dr. Bessel Van der Kolk's book The Body Keeps Score [6]. After experiencing a traumatic situation "the survivor's energy now becomes focused on suppressing inner chaos," which can result in further physical and somatic symptoms [6]. The integration of psychological and behavioral sciences of DST enhances therapists' ability to describe, explain and optimize the human development of their individual clients. It dialectically synthesizes the underlying contextual and also cognitive effects on the individual, which are highlighted as fluid, dynamic and process based.

Case Study

For the purpose of this article, the following client's name has been changed in efforts to follow confidentiality guidelines as per HIPAA regulations. Devon is a thirty-five year old, heterosexual, Caucasian, female, currently living with her parents and eight-year-old autistic son. Devon is currently employed as a server at a local restaurant, working during the day so she can care for her son in the evenings, after he returns home from school. She had recently moved home to New Jersey with her parents from North Carolina in attempt to regain sobriety. She separated with her long-time, emotionally and physically abusive boyfriend six-months prior to treatment, who is not the biological father of her son. Devon has sought out treatment upon recommendation of her individual therapist due to her struggles with alcohol abuse. At the time of intake, Devon presented motivated for change for personal success, but also to benefit her ability to parent her child with autism. Upon completion of Devon's Biopsychosocial Assessment, it has been recommended that she enter an Intensive Outpatient Program (IOP) for weekly structure and assistance with her sobriety.

Upon treatment start, Devon identified struggling with alcohol abuse, consuming 1L bottle of wine each night. She noted her drinking would take place once her son was asleep, and therefore did not recognize this as an issue prior to working with her individual therapist. Devon verbalized she had struggled with almost daily cocaine use, marijuana use and infrequently other hallucinogens, though denied use within the past year. When first asked about the personal views of her use, she noted using other substances aside from alcohol because of the abusive relationships she had recently developed courage to leave. Throughout care, Devon mentioned on multiple occasions that she had experienced sexual trauma when she was an adolescent, though felt as if she had already processed the experience and had moved passed her history. It grew evident through a trauma-informed therapeutic focus that, Devon utilized substances to suppress

the physical and emotional effects of the trauma experienced at age fourteen from her inability self-regulate [17].

Issues and dynamics essential to this case are identified as internal and external systems through the use of DST. The first external system is that Devon moved in with her parents to assist in childcare for her son along with gaining geographical distance from her abusive boyfriend. A client experiencing trauma struggles with basic trust, autonomy and initiative, therefore views himself or herself as a burden formulate [5]. The second external system is Devon raising child with autism. Parents with a disabled child experience decreased levels of general and mental health, due to increased stress [18]. The last external system incorporates processing the traumatic experience Devon later discloses in treatment, that this is the first time she felt not judged in discussing sexual trauma that had been suppressed for over twenty years. As trauma therapy invokes intense emotion, many survivors extend to great lengths in efforts to avoid it [5].

The first internal system includes self-medicating acting to suppress trauma because it feels safer. A hyper-focused processing style coupled with the desire to mask or manage inner-pain through excessive use of substances [3]. The second internal system is avoiding egocentrism of her fourteen-year-old self to fuel self-blame, shame and guilt for past actions. Childhood sexual abuse is correlated with increased depression, guilt, shame, and self-blame," [19]. The last internal system reflects on empowering self to enable healthy relationships in the future and gain empowerment to ask for appropriate support. Treatment models emphasize emotional betrayal and shock which naturally encouraged distance from intimate partners, leading to unhealthy and one-sided relationships.

As treatment continued, Devon disclosed her first sexual experience was of a multiple rape episode when she was fourteen years old, in which she went to a party with a female friend of hers. She became integrated with a troubled crowd of twenty to thirty year old men, who had taken turns penetrating Devon in multiple orifices, while ejaculating on her body at different times. She was then left alone, apart from her friend until early the next morning, when she rode the bus home, snuck into her house and never told her parents of the experience. It became evident throughout the course of treatment that Devon had been utilizing multiple substances throughout the course of her life to attempt in self-medicating this emotional, physical and interpersonal impediment of her body. Khantzian suggests self-medicating with substances represents a lack of self-regulation creating an absence of emotional sobriety. Self-medication with compulsive and destructive behaviors, which Devon later acknowledged in treatment, initially assisted in her gaining a numbing response, a phenomena that proves the accuracy of Self-Medication Theory.

In working with clients, such as Devon, with a multifaceted Co-occurring Disorder, it is essential to ensure the treatment for trauma is not moving too fast for the client to fully process the experience [5]. Additionally, reflecting on traumatic past experiences in therapy has a high relapse rate of substance abuse, as "self-medicating is all about not feeling pain," [3]. The dyad within the therapy room is essential to the recovery process; whereas the therapist must use and normalize the language of the survivor, engage in discussion of sexual health, validate their experience through empowerment and provide support [14]. Devon identified that she had not experienced a non-judgmental, client-centered, environment where she felt able to discuss the sexual trauma, therefore leaving her to feel her self-process of self-medication was allowing her to accept her past [19].

Devon's parents had engaged in family sessions to further discuss their role in the support of Devon, her addiction and her sexual trauma. This was the first time Devon disclosed the rape experience to her parents, leaving her parents in heartbreak and anger. The changes caused from sexual abuse range from emotional, social, sexual and also familial dysfunction [20]. In disclosing the past to her parents, Devon verbalized relief and also the ability to feel she could rely on her parents for the support and validation she needed throughout the treatment process. As Herman emphasizes, highly resilient people have the ability to make use of shock for purposeful action during a stressful event, where as ordinary people experience paralysis and become isolated by terror [5]. Relevantly, Devon's parents explained that as a child, she presented shy and introverted characteristics. After Devon experienced sexual trauma, she became more extroverted, yet highly detail oriented when engaging with others [5].

Devon's parents verbalized during multiple family sessions that they have never experienced or have known to experience sexual trauma within their family. Devon's disclosure of her fourteen-year-old trauma was of great shock and immediate feelings of guilt, as her parents were struggling to identify how her substance use derived. Through the use of a genogram, it became evident that due to the genetic predisposition of addiction within Devon's maternal and paternal family, the propensity of addiction was prevalent [21]. With a family history of addiction, it became apparent that Devon was predisposed to repeat the addiction cycle [21].

The culture of Devon's family's foundation is of open and honest communication, along with support and respect. This was especially helpful in Devon's recovery as the clarity and assurance of not feeling abandoned or shamed reiterates safety within the recovery process [6]. Socially, Devon is a part of the AA community to develop an understanding of healthy relationships without the use of alcohol and other drugs. According to founder of developmental research and psychologist Erik Erikson, Devon was experiencing the Intimacy vs. Isolation internal conflict throughout her enrollment in IOP. Developmentally Devon was in the mix of potentially losing her own adult identity and leading herself into isolation, due to potential threats from others, based on her experience of sexual trauma [22]. This is the state if development that assists in the cycle of exclusion and isolation, which Devon's trauma ignited for many years [23]. It was crucial for Devon to learn about healthy intimacy through examining the difference between intimate and lustful relationships in efforts to build on the development of trust, openness, honesty and self-respect [23]. Consideration of the entire system is important in assisting a client to notice all resources, risks, supports and drawbacks surrounding them throughout the recovery and processing trauma procedure [17].

The Intensive Outpatient Program Devon enrolled in required attendance three times per week for a three-hour group, including a family group, in conjunction with individual weekly fifty-minute sessions with a primary therapist. A mental status exam was completed weekly to assist in assessing client presentation, behavioral and cognitive functioning. Devon predominantly was well dressed, and her behavior was within the normal range. Devon's mood and affect changed based on the context of the group or individual session, however remained congruent. Devon's thought process, insight and content remained appropriate, presenting coherent and oriented within all three dimensions of time, place and person. Her motivation for treatment presented internal and external, as she discovered the root to her use through system's work and identified onset to emotional avoidance and compulsive behaviors, which was her trauma [17].

Devon was encouraged to challenge her comfort in isolation of substances and accept vulnerability in processing trauma. Avoidance is a major obstacle with survivors but embracing vulnerability to avoid detachment from others is an important step in the recovery process from trauma [12]. This cognitive change enabled Devon to accept herself and allow the healing process to take place throughout her treatment. Upon successful completion of IOP, Devon was discharged and recommended to continue outpatient services with her individual therapist to further indulge in the ongoing trauma recovery process [5].

Conclusion

The multifaceted impacts of a co-occurring diagnosis comprised of SUDSs and trauma has a large impact in a client's desire for change and ability to regulate thoughts, behaviors and emotions. The literature review of COD, self-medication, Substance Use Disorders and sexual trauma is empirically formulated to provide an advanced presentation of the adverse effects of addiction and sexual damage. Through the use of Dynamic Systems Theory, both internal and external systems of a client who has been impacted by trauma are explored to develop a broad understanding of the situation and also to assist in the exploration of the change process. With the compassion of a trauma-informed therapist and a desire to de-stigmatize the hurt a co-occurring client experiences daily, self-regulation, implementation of healthy coping mechanisms and empowerment can be achieved. The case study of Devon was presented to identify ways DST is utilized throughout the healing process for both substance abuse and overcoming the detrimental outcomes of a sexually traumatic experience.

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