Trauma Informed Care (T.I.C.): Exploratory Case Studies
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Introduction and influences.

- Addiction recovery model: Psycho-education, psychotherapy, Twelve Step participation (Fairmount). Now, encouraged but not required.
- First sex addict client (The Villa)
- 1992 to 1994--In-patient therapy in The Sanctuary, sex and love addiction embedded a trauma treatment program.
- Consultation with Dr. Richard Kluft, expert on dissociation.
Abstract:

- Trauma Informed Care (T.I.C.) has become normative in addiction treatment in the last decade (Brown et. al., 2013) but has been a part of Sex and Love Addiction treatment for decades (Griffin-Shelley, 1995). The workshop will explore the role of trauma treatment in recovery through the use of case studies. These cases require long-term, psycho-dynamically oriented therapy integrated with addiction recovery. T.I.C. begins with relapse prevention especially in terms of understanding individual triggers and the degree of internal splitting in clients. The focus on trauma is particularly valuable with clients who struggle with maintaining sobriety despite involvement with Twelve Step fellowships and both individual and group psychotherapy. When addicts refer to active addiction as being “in my addict” or speak of their internal “addict voice,” the question arises: Do they have ‘multiple personalities’ (Hatch, 2014)? We will examine how to interpret and use this inner split to promote psychological health.

- One case started with addiction recovery and involved viewing illegal images. David used Twelve Step programs to get sober but never really developed meaningful relationships. Further exploration revealed multiple personalities and treatment evolved into clarifying his trauma and integrating his parts. Sam has been involved in Twelve Step programs and treatment for ten years without achieving sobriety. His work focused on identifying his “reactivity” and understanding how profoundly damaged his sense of self was. Leslie needed intensive support for a high conflict custody/co-parenting situation. Untangling her current stress from her post traumatic stress and determining how these interact was essential.
How the mind defends against shame, trauma.

- Dissociation: Splitting into parts.
- Mind works by association, e.g., triggers.
- Extreme example: *Sybil*, Multiple Personality Disorder (MPD), Now Dissociative Identity Disorder (D.I.D).
- The “addict” part “hijacks” the brain.
- Unhealthy way of coping like defensiveness.
- Provides relief, but adds shame, self-loathing.
- Two personalities: Dr. Jekyll and Hyde.
- Trance-like state. Hyper-focus.
- Safety with the illusion of intimacy (Hatch).

- The presence of dissociation in sex addicts was hypothesized by the authors based on clinical experience. Families and friends of sex addicts commonly refer to their “Dr. Jekyll/Mr. Hyde” personalities. The Structured Clinical Interview for Dissociative Disorders was used to survey 31 inpatient self-identified sex addicts who were in treatment in the addictions services track of a trauma program. Two-thirds of those interviewed were identified as having a dissociative disorder: 10 (32.26%) had Dissociative Identity Disorder, another 10 (32.26%) had Dissociative Disorder Not Otherwise Specified, and one (3.23%) had Depersonalization Disorder.
“Small t” versus “Big T” Trauma:

• Physical violence. Observing violence.
• Emotional violence, threats, shaming.
• Chronic every day neglect, rejection, abandonment.
• Eroding, then destroying self-worth.
• Family-of-origin trauma under addiction failure and shame: A double dose.
Complex PTSD

https://www.ptsd.va.gov/professional/ptsd-overview/complex-ptsd.asp

- Re-experiencing
- Avoidance or numbing
- Hyperarousal
- Additional criteria include:
  - Emotion regulation problems, or difficulty controlling emotions
  - Altered relational capacities such as difficulty sustaining relationships and feeling close to others
  - Attention and consciousness issues, such as disassociation
  - Adversely affected belief systems. Meaning pervasive thoughts and feelings of being worthless, defeated and a failure, as well as being filled with guilt and shame
  - Somatization or somatic distress, which is characterized by the recurrent appearance of multiple medical symptoms with no explanation or apparent cause
Cases 1: David

- Three kids, works in technology, masters and doctoral course work. Siblings are damaged but do not seem to recognize it or get help. Wife’s family are superficial like she is and do not look below the surface. When he tries to talk to her, she seems to not understand. When she went to therapy, she did not know what to talk about and complained that the therapist did not provide enough direction.

- Long-term sobriety, could not connect in program, very bright, under achieving in school, many inner children/voices, no confidence. Hard to feel anger towards parents and easily blames himself. Cannot speak up to wife or at work. Worries how well he is parenting his kids.
David (Continued)

- His mind is “shattered,” “splintered,” “shards.” Fragments, not personalities.
- Fantasies and intrigue with being “Super” and with punishing and harming others. Grandiose or self-loathing.
- Part of him wants to “annihilate” him.
- Fears the “flood gates,” being overwhelmed.
- Feels “adolescent” and sexual attraction is to this age female.
- Nightmares unless he takes medication.
- Occasional use of alcohol to numb.
- Cannot forgive “current me” for not rescuing “two-year old me.”
Case 2: Sam

- One child, works in hospitality industry, formerly book store forced closing due to big box stores.
- Smart, friendly, good sense of humor. Loved flying in high school and worked to pay for his own flying lessons only to have parents say he’d “never make it in the military.” Later, found private flying schools, but they would not pay for it, nor would they pay for intensive therapy that his psychiatrist in college recommended.
- Fragmented self, 10 years of recovery without sustained sobriety, rejected by rehab for his “sensitivity,” “beat up” by initial addiction recovery treatment, feels “alien,” suicidal, responding to support, care, concern, 3 times/week, caring kids, financial collapse, rejecting parents, “looser” self-image.
- Mother yelled on the phone with her mother. Parents fought every day. Hyper-sensitive to raised voices and swearing.
Sam (continued)

• “Compare and despair.”
• Pleasant, high achieving at work then eats alone and experiences profound loneliness.
• Intellectual understanding but dissociated from emotional (child) self.
• “Looser” identity; rejects feedback about good qualities like loving, smart, humorous, persistent.
Case 3: Leslie

- Two kids, healthcare industry, two masters degrees, childcare experience. Siblings: brother enmeshed, sister found another family with her in-laws but does not recognized her children’s issues.
- Son has anxiety symptoms and was in counseling with their co-parenting therapist, but child’s father refused additional counseling since co-parenting therapy ended.
- Unexpected pregnancy at 40, “looser,” identity fostered by profound paternal neglect, striving to be “good” and get their attention, parental/child’s father’s negative voices are overwhelming and powerful, 3 times/week, male sponsor became seductive and kept her secret from wife.
- History of depression with suicidal episode. Lots of therapy including EMDR. Medication. Hard worker, does her homework. Organizes volunteer groups. Disappointed in friends who do not have children so do not support her.
- Mother OCD, sexual abuse victim, locked them out of the house on Saturdays, had to play in the basement, could not wear shoes in the house due to dirt, would not talk to her for days.
- Father use physical punishment, did not challenge mother or get her help focused on work.
Leslie (continued)

• Bouncing from “I can’t do this” to “radical acceptance.” Painful aloneness.
• Custody conflict echoes parental abuse: She’s “crazy,” “lazy,” and too demanding.
• Intense reaction to “gaslighting” from parents, co-parent, and lawyers/court.
• Escapes with alcohol, eating, exercise binges.
• Suicide (homicide?) “always in the back of my mind.”
Long-term and intensive therapy (3 time per week).

- Fear of being alone while isolating: Two parts of self, needs hidden.
- Building and rebuilding self-worth, self-esteem, foundation.
- Parent, Child, Adult parts (Superego, Id, Ego).
- Unmet dependency needs. Tend to be co-dependent
- Partner’s mood determines their mood.
- People-pleasing.
- Love addiction.
- Difficulty with affirmations, hugging themselves, nurturing.
Isolation.

- "Sensitivity." Distrust of others.
- Reframe as P.T.S.D. hyper-reactivity.
- Neediness. Never enough.
- Hurt, disappointment.
- Resentment.
- Guilt, shame.
- Profound feelings of being "alone."
Suicidality:

- Hopelessness, despair.
- Feeling like a burden, worthless.
- Wanting to kill. Homocidal.
- Empowering anger. Victim to victimizer.
- Eroticized rage
How to strengthen resilience, reduce defenses.

- Mindfulness the opposite of Dissociation.
- Heighten awareness and tolerance of emotions.
- Adopt an experimental attitude, trial and error.
- Do not take it personally, e.g., “I’m bad or wrong.”
- “Honesty is the key to sobriety.” Identify your needs. Express them.
- Share your confusion, anxiety, and fears. Ask for help.
- Seek resolution of fears, conflicts, and anger.
- Develop empathy. See the impact of your “secret” actions.
Transference and ethical issues.

• Goal: Positive support, trust, safety, consistency.
• Counter-transference: Anger, Sexual feelings (ours and theirs), Enabling and Colluding (Karpman’s Triangle), Feelings of Powerlessness.
• Reporting requirements (by state) for sex crimes, violence, child and elder abuse.
• Battered partners (both can be victims).
• Boundaries including waiting area, phone and email contacts, records.
• Patients acting out with other patients.
• Should you Google your clients?
• Self-disclosure (including personal information on the Internet).
• Terminating therapy: When and How?
• Diagnosis.
• Treatment Strategies.
• Competence.
• Communication with other therapists (e.g., group, couples).
• Questioning the ethical behavior of peers.
References


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