

Chapter 6

Trauma and Substance Abuse Prevention

Brady and Sonne (1999) discussed three important factors related to averting negative consequences following trauma: coping skills, problem solving skills, and social support. These factors address what the individual is capable of doing for himself or herself at any given time, as well as what outside help is available to the individual at any given time.

This section will examine how prevention addresses these and other factors in order to expand this discussion.

Prevention Overview

The transformation of substance abuse prevention programs since the 1960's has been profound. During the 1960's and into the 1970's, there was one primary type of prevention model available, the **Information Model**. This model assumed that youth used substances because they were ignorant of the dangers and adverse consequences of drug use, and attempted to educate youth in classrooms about drugs. The primary drawback to this model was that too often a “scare tactic” approach was used to deter persons from drugs and alcohol use. This approach lacked credibility and in part undermined any overall strengths of the information model because it does not respect the decision making ability of the audience.

The information model continued throughout the 1970s, and while demonstrating acquisition of knowledge, all evidence seems to indicate that these programs were ineffective in impacting upon substance use. The idea that knowledge alone would lead to attitude change, which in turn would change behavior was not scientifically proven, and in fact, nationally, drug abuse reached an all time high in America by 1979.

Substance abuse prevention is a holistic process aimed at promoting health enhancing behavior, and reducing health compromising behaviors.

In the early 1980's, an **Alternatives Approach Model** gained attention. The theme involved young people in non-drug related activities (recreational programs or special projects to relieve boredom and increase self-esteem). The belief was that this participation would counteract any tendency to use substances. While a large share of prevention resources were invested in these types of programs, there was little evidence to support their effectiveness as deterrents of substance use.

The 1980s also ushered in both the “**Chemical People Project**” Community Action Group initiative and the “**Just Say No**” initiative. This approach resulted in stronger community involvement, however, it failed to take into account the complex interactions of biological, social, and psychological factors. There was also a realization that teaching kids to say “No” was insufficient and that programs needed to include opportunities for skill practice and application.

In the mid-1980's, prevention programs developed a **Social Competency Model**, to enhance personal and social competency skills by teaching broad coping skills. The theme was based on assisting young people to develop prosocial abilities and skills instead of specifically targeting substance abuse prevention. In turn, they will make correct choices concerning substance use. Alone, this also failed to demonstrate effectiveness.

The **Social Environmental Model** emerged in the late 1980s and placed more emphasis on other areas of young people’s lives such as the family, school climate and the community. The model highlighted resistance skills and normative education. Programs using this approach have shown encouraging results, especially for alcohol and marijuana use.

In the late 1980s and early 1990's the **Biopsychosocial Model** emerged which stressed the importance of the interaction between a person and his/her internal and external environment. This model blended with another similar model in the late 1980s and early 1990s, the **Public Health Model**. The Public Health Prevention Model paralleled the Public Health Disease Model and analyzed alcohol and other drug use in the same context used for other diseases: the host, the agent and the environment. Interventions were designed to impact upon all three areas. Both models brought additional strengths to the overall prevention profession.

The “Just Say No” initiative resulted in a realization that teaching kids to say “No” was insufficient and that programs needed to include opportunities for skill practice and application.

The Public Health Disease Model analyzed alcohol and other drug use in the same context used for other diseases: the host, the agent and the environment.

In the early-to-mid-1990s several youth development models were developed including **America’s Promise, Character Counts, Positive Youth Development**, and the **Assets Model**. These were initially exciting models because they were research-based and they were youth focused. The prevention community recognized several inherent flaws, however, and these models were never fully embraced.

In the mid-1990s to the present time, AOD prevention activities are based on research demonstrating the impact of both risk and protective factors in life functioning, especially as this is associated with an increased use of alcohol and other substances as well as other problematic behaviors - crime and violence, academic underachievement, teen pregnancy, etc. This model, the **Risk and Protective Factors Model**, sought both to reduce or eliminate risk factors and enhance protective factors.

Also, at about this time another potentially successful prevention model evolved - the **Environmental Prevention Model**, as was identified and encouraged as originally highlighted in the Nationally Structured Evaluation Outcome Study. The Environmental Model focuses on areas that would demonstrate the greatest impact on a target population, i.e., laws, norms and policies. Earlier models did not assess the significance of these areas, nor target them in a comprehensive manner.

Together, the Risk and Protection Model and Environmental Model are demonstrating the most promise for prevention efficacy, and current science-based models of effectiveness attest to this.

A final word must be said about the Principles of Effectiveness. Several findings have been identified as critical to the success of any and all prevention efforts. The NYS Division of Alcoholism and Alcohol Abuse first identified several of these principles in the landmark 1986 Five-Year Comprehensive Plan for Alcoholism Services in New York State “Focus on Prevention.” These have been periodically updated and integrated into other state campaigns and initiatives. They were restated in the 1987 Five Year Plan, the 1995 Five Year Plan, and have evolved and have been published through the annual local services plan with the Local Governmental Units (LGUs).

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There is a set of Prevention Principles for Children and Adolescents, recommended by the National Institute for Drug Abuse. There is a set of Principles of Prevention Effectiveness from the United States Department of Education, which also includes evaluation and utilization requirements.

Perhaps the most widely accepted set of principles are provided by the Center for Substance Abuse Prevention. They are scientifically defensible and can help service providers design and implement effective programs. The principles are divided into four domains: Individual/Peer, Family, School, Community/Environmental. CSAP states that for any substance abuse prevention initiative to be effective, these principles must be incorporated into each and every strategy and campaign. The principles are cited in “Principles of Substance Abuse Prevention,” Center for Substance Abuse Prevention, DHHA publication No. (SMA)01-3507, Printed 2001, and are found at: www.samhsa.gov/centers/csap/modelprograms/pdfs/pubs_Principles.pdf.

Historically, several early intervention prevention programs have been developed and utilized: Student Assistance Programs (which originated in a need to help children of alcoholics), Employee Assistance Programs, Health Intervention Services, Drinking Driver Programs, Crisis Intervention Services, etc. New curricula and strategies such as Life Skills, Brain Power, Reconnecting Youth, Strengthening Families, Mentoring, Environmental Approaches, and Community Mobilization Efforts such as Communities That Care are programs that are also yielding excellent results. (Promising and Proven Substance Abuse Prevention Programs, Center for Substance Abuse Prevention, DHHS Publication (SMA)01-3506, printed 2001.)

Today, substance abuse prevention is a holistic process aimed at promoting health-enhancing behavior and reducing health-compromising behaviors. Strategies are becoming more comprehensive and inclusive, incorporating the six primary CSAP strategies: Information dissemination, prevention education, alternatives, problem identification and referral, community-based processes, and environmental approaches.

Prevention Goals

- ❑ Prevent abuse of alcohol and other drugs
- ❑ Delay the age of first usage
- ❑ Prevent or delay progression from experimentation to regular use, to abuse, to chemical dependency
- ❑ Prevent or delay expansion for the use/abuse of one drug to a wide variety of drugs
- ❑ To prevent further deterioration through early identification and intervention.

Prevention Domains:

Influenced by the bio-psycho-social model approach, prevention programs aim to address the four domains of influence in order to comprehensively influence choice in a positive direction.

- ❑ individual/peer biological, psychological dispositions, attitudes, values, knowledge, skills, problem behaviors, norms, activities, bonding.
- ❑ school bonding, skills, recognition, clear expectations, policy, healthy beliefs.
- ❑ family binding, skills, recognition, clear Expectations, healthy beliefs.
- ❑ community/environment bonding, norms, resources, awareness, mobilization, norms, policies, laws, sanctions.

The individual choices made regarding the use and abuse of ATOD is therefore a complex interaction of domain influences.

Each of these areas play some role in how an individual comes to think about and participate in alcohol, tobacco, and other drug (ATOD) consumption. The individual choices made regarding the use and abuse of ATOD's in therefore a complex interaction of domain influences.

Risk and Protective Factors

Within each of these domains exists factors that can positively or negatively influence individual choices regarding ATOD usage. Those factors which positively influence individual choices are termed protective factors. Those factors which negatively influence individual choices or appear to predispose individuals toward ATOD abuse are termed risk factors. Risk factors exist prior to drug usage and are statistically associated with an increase in probability of drug abuse. Prevention therefore seeks to eliminate or reduce risk factors.

While a detailed discussion of Risk and Prevention Factors is beyond the scope of this manuscript, the following offers some examples of how prevention views risk factors and seeks to enhance protective factors:

Risk Factors:

- Laws and norms favorable toward ATOD use and abuse
- Family ATOD behaviors favorable to ATOD use and abuse
- Peer groups with favorable behaviors and attitudes toward ATOD use and abuse
- No positive role models available to a child

Protective Factors:

- Changing social norms regarding ATOD use and abuse
- Enforcement of school policy regarding ATOD use and abuse
- Enhancement of problems solving skills and life skills
- Enhancement of positive peer relationships that provide positive recreational alternatives.

Prevention therefore seeks to reduce the influence of risk factors, and enhance the influence of protective factors toward the achievement of the overall goal(s) of prevention.

With the goals of prevention in mind and with a comprehensive understanding of the domains and the risk and protection factors, the specific type of intervention is applied based upon the population needs.

Preventive Interventions

There are three categories of preventive interventions which organize service delivery around the needs of the population being served at the state of substance use or abuse. The 3 categories are universal, selective, and indicated.

Universal preventive interventions: Are targeted at the general population where individual risks have not been assessed. These interventions might include information dissemination, prevention education, alternative activities, etc.

Selective preventive interventions: The interventions are targeted at individuals or subgroups of a population who are considered to have a significantly higher risk of substance abuse than those in the general population. For example, a particular family skills program or prenatal program, SMART leaders program to increase knowledge about sexual activity, or tutoring programs to assist with academic achievement.

Indicated preventive interventions: These interventions are targeted at individuals in high-risk environments who have signs or symptoms that foreshadow a substance disorder or have biological indicators and a potential for disorder but do not yet meet diagnostic levels. For example, a program aimed at improving school attendance, social skills training, and school based support groups.

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Resiliency

Another important concept in prevention is that of resiliency. Studies on resiliency have contributed to our understanding of protective factors.

This literature has examined **the ability of individuals to survive and thrive even in the face of unfavorable life circumstances.**

In a longitudinal study which followed the social development of children who were considered at high risk due to poverty, parents with low education, families in discord or divorce, family alcoholism or family mental illness, 27% “grew into competent adults who loved well, worked well, and played well” (Werner, 1989, p. 131). An examination of their resiliency compared with the children who grew up to be less well adapted identified these protective factors in the individual, the family and society:

1. Individual factors - likeable, high activity level, low excitability, high sociability, seeks new experiences, able to concentrate, good problem-solving skills, are able to ask for help.
2. Family factors - family has fewer than 5 children, close bond with at least one caretaker (may be substitute parent within family), recruited surrogate parents when biological parent was not available.
3. Society - support from classmates, neighbors, churches, clubs. School used as home away from home.

It is essential that providers make contributions to protective factors in areas that are approachable and available to them. Some of the key protective factors in prevention that mirror the resiliency literature follow accordingly.

- Having a caring and supportive relationship with at least one person
- Communicating consistently clear, high expectation (realistic based upon individual capacity) to the child
- Providing opportunities for the child to participate in and contribute to his or her social environment.

Resiliency is the ability of individuals to survive and thrive even in the face of unfavorable life circumstances.

The role of prevention in the face of trauma lies then in determining the risk and protective factors specifically related to the experience of trauma, increasing protective factors, decreasing risk factors in order to empower individuals and systems to deal constructively with life trauma.

The remainder of this chapter will address the role of prevention in following the experience of trauma.

Understanding Coping Mechanisms

Coping Mechanisms are the thinking, behaviors, and emotional responses that a person utilizes in order to respond to stress and to continue to function.

These mechanisms may be positive in that they increase the ability to recover from a trauma and the ability to function, or they may in fact be negative and decrease the ability to recover and function. They differ somewhat from what providers term ‘life skills’ and ‘problem solving skills’ in that they are specific to reacting to traumatic events. While life skills and problem solving skills may in fact be components of coping, those skills tend to be aimed more at everyday functioning.

Both positive and negative coping mechanisms ultimately provide the person with feelings of relief from the trauma. For example, using support systems to talk about a trauma assists in working through the trauma thereby working toward recovery and providing emotional and intellectual outlets. Using drugs for physical and psychological numbing may provide temporary relief from a traumatic experience but avoids necessary psychological processing and may cause lower functioning capacity.

The literature and research on crisis counseling is extensive. Caplan (1964) studied effective coping skills; those skills, traits, or actions which appear to influence a person positively in their management of traumatic experience and the impact that experience has upon their lives.

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Effective Coping Behaviors

1. Exploring reality issues and searching for information
2. Freely expressing both positive and negative feelings and tolerating frustration
3. Invoking help from others
4. Being aware of fatigue and pacing coping efforts
5. Maintaining control in as many areas of functioning as possible
6. Prioritizing needs and addressing them accordingly
7. Reducing problems into manageable pieces and addressing these one at a time.
8. Willingness to consider and implement alternate solutions, being flexible and willing to change.
9. Trusting in oneself and having an optimistic outlook.

(Based upon the work of George Caplan, 1964)

Every hardship; every joy; every temptation is a challenge of the spirit; that the human soul may prove itself. (Henry Fielding 1700's)

Personal Growth after Trauma

As stated in the Introduction section of this document, this paper intends to consider, not only how people recover from trauma, but the possibility of transcending trauma. The following will briefly discuss issues of growth by examining self-actualization, religion and spirituality.

Self-Actualization

Self-actualization is the knowledge of one's true, inner self. And the fulfillment of the possibilities of one's character or personality. This term was first used by Kurt Goldstein to describe the motivation to realize individual potential. It was later used by Abraham Maslow as the final phase of human fulfillment. According to Maslow, human beings first meet other, more basic needs (physiological, security, social, and esteem) before they can advance to actualization which involves transcendence over simple 'coping' through the following:

- independence,
- autonomy,
- a tendency to form deep friendships,
- a "philosophical" sense of humor,
- tendency to resist outside pressures, and
- a general transcendence of the environment, rather than a simple "coping".

Religion, Spirituality and Spiritual Transformation

Immediately after the 9/11 tragedy people flocked to churches, synagogues, and mosques, in the hope of finding comfort, understanding, or some explanation. Even though the attendance increases later dwindled, the message remains clear, that people seek personal assistance, meaning and understanding from faith based organizations following traumatic experiences. In the field of substance abuse, spirituality especially has long been a part of self-help groups and treatment.

Definitions and Distinctions

RELIGION - Associated with organized practice of beliefs associated with a supreme being.

SPIRITUALITY - Believing in , valuing, or devoted to some higher power, without the necessity of practice or worship (Worthington, et al, 1993; Morgan, 2000)

SPIRITUAL TRANSFORMATION: Radical reorganization of one's identity, meaning, and purpose in life. (Pargament, 1997) Generally involves:

COMPONENTS OF SPIRITUAL TRANSFORMATION

- A PROFOUND CHANGE IN THE SELF.
- SUDDEN OR GRADUAL PROCESS
- RADICAL IN CONSEQUENCES - NEW CENTERING OF CONCERNS, INTERESTS, BEHAVIORS
- SENSE OF "HIGHER" PLACE, FREE FROM PREVIOUS PROBLEMS
- OCCURS IN SOCIAL CONTEXT, NEW IDEAS RESULT IN CHANGED HABITS OF LIFE (Hood, et.al., 1996)

Substance Abuse and Spirituality

Spirituality has long been associated with substance abuse treatment. In the 1920's a spiritual movement known as the Oxford group put forth the notion that life's problems could be solved through personal spiritual changes. In the 1930's this concept became the foundation of Alcoholics Anonymous, incorporating issues of spirituality into its guiding principles. In terms of recovery, what is unique about this movement is the reliance upon God or a "Higher Power" in order to come to a spiritual awakening which necessitates abstinence. Indeed, seven of AA's guiding 12-Steps directly mention a Higher Being or spirituality, and prayer may often be a part of the meeting.

The twelfth of AA's 12-steps requires the recipient to help other alcoholics. Because so many of the staff in treatment facilities were and are themselves recovering persons, this expectation has greatly expanded the application of the principles and thus the orientation to spirituality in the recovery process.

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Spirituality Research

In a review of the research on spirituality and mental health, Schumaker (1992) concluded the following (as summarized by Kelly, 1995):

- Religiosity is positively associated with measures of personal adjustment, and appears overall to be marginally helpful in times of crisis.
- Psychiatric patients are far more likely to be nonreligious than are "normal" adults.
- Religion tends to have a positive effect on mental health, defined as the absence of psychological symptoms.

- Intrinsic religiousness (spirituality) is positively correlated with the seven mental health criteria of absence of mental illness symptoms (appropriate social behavior, freedom from worry and guilt, personal competence and control, self-acceptance and self-actualization, unification and organization, and open-mindedness and flexibility).

- **Religiousness has a beneficial association with, drug use, alcohol abuse,** suicide risk, delinquent behavior, divorce, marital satisfaction, psychological well-being, depression, and physical health and longevity.

In her research on disability and spirituality, Do Rozario (1997 p. 432) concluded that "critical life experiences such as disabilities can enable people to develop personal resources and to grow . . . an inner awareness of wholeness...this inner awareness of wholeness, in spite of all odds, points to an implicate experience of life which can transcend form and matter" (p. 433).

Thus, the utility of religion and spirituality in times of traumatic experience appear to have at least three functions, 1) to maintain positive life functioning, 2) to assist persons at times of crisis, and 3) to bring about a heightened self through a spiritual awakening or transformation.

The following chapter will utilize the information on risk and protective factors, resiliency, and coping skills in order to present a prevention paradigm that is specific to trauma and the role of the prevention provider. In addition, it will offer some suggestion regarding the place of self-reflection, self-actualization, and spirituality as it relates to trauma.