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Trauma:

A Gateway to Substance Use Disorder

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Substance Use Disorder (SUD) has been proven, through years of research, to be tightly connected to experiences of trauma. Through our specific research and data here with the Delaware Drug Overdose Fatality Review Commission (DOFRC), we have seen that at least 37.4% of decedents experienced at least one traumatic event. This number only considers those that self-reported; it is more than likely an underrepresentation, since medical examinations and police intervention do not typically assess specifically for trauma. Alarmingly, of that 37.4% self-reported trauma, only 8.5% reportedly received any counseling.

Given the number of decedents with a history of trauma and their limited exposure to counseling services, we recognize the need to better address the lack of counseling services received. We recommended in our 2021 Annual Report that treatment providers should have better access to trauma specific training and education to expand access to trauma specific counseling services. Further analysis of practitioners' and treatment providers' current approach to trauma-affected SUD patients can help inform the implementation of trauma-specific approaches.

Trauma comes in many forms and is often individual-specific, but a common thread is that it appears to be one of the most prevalent gateways to SUD. Wayne Munchel, for the Children's Mental Health Network, writes that, "People who experience four or more ACEs (Adverse Childhood Experiences) are 500% more likely to abuse alcohol. People who report five ACEs or more are seven to ten times more likely to report illicit drug abuse. A jaw-dropping data point indicates that individuals who survive six or more ACEs are 46 times more likely to be IV drug abusers than people who report no ACEs."[1]

Witnessing an overdose is traumatic. We found that 15% of decedents in the DOFRC analysis had previously witnessed an overdose. Of those, none reported subsequent therapeutic intervention. In 2020, 447 fatal overdoses occurred; that number rose to 515 in 2021 for 962 fatal overdoses in two years. That's 962 specific instances of directly-inflicted trauma.

In our review of deaths from 2019, we found that 25.7% of decedents were discovered by their significant others, 19.3% by parents, and 11% by friends. These findings highlight that those closest to the deceased are often the ones who are also emotionally attached to them, indicating that they will experience significant grief. As Fleury-Steiner and Stout have noted, individuals facing this trauma in Delaware often do not have access to—or do not know of—resources for navigating their grief, and experience symptoms of Complicated Grief Disorder at higher levels than those who connect to help seeking resources.[2] Providing these individuals with counseling, peer support, and support group resources at the time of death would assist in mitigating some of the harms experienced from losing a loved one to an overdose.

Another traumatic event is sexual assault. A University of North Texas study found that 85.12% of a sample population experienced at least one traumatic event. The study also found significant

gender differences in that more women reported experiencing sexual abuse, and more men reported witnessing violence:

> Sexual assault history is associated with higher risk of problem drinking and drug use in women, yet little is known about mechanisms linking trauma histories in general to women's drinking or drug use problems. This study examined how various types of trauma, substance use coping, and PTSD relate to past-year problem drinking and drug use in women who experienced sexual assault. Data from a large, diverse sample of women who had experienced adult sexual assault were analyzed with structural equation modeling to test a theoretical model of the relationship between trauma types, substance use coping, PTSD symptoms, and past-year drinking and drug use. Results show that PTSD symptoms fully mediated the association between non-interpersonal trauma and the use of substances to cope. However, the association between both interpersonal trauma and child sexual abuse severity on substance use to cope was only partially mediated by PTSD symptoms. In turn, use of substances to cope fully mediated the relationship between PTSD and problem drug use as well as partially mediated the effect of PTSD on problem drinking. These results suggest that different trauma types and substance use coping may be important risk factors distinguishing sexually assaulted women who develop PTSD and problematic substance use from those who do not. Identifying women's histories of different traumas may help to identify those at greater risk for substance use problems.[3]

Being unhoused or living in unstable housing can be traumatic. When something that most of the population is able to take for granted like housing is absent, it can be traumatic for that individual that is unhoused or living in unstable housing. DOFRC identified almost 40% of the decedents in our sample as unhoused or unstably housed. Our findings highlight significant differences between treatment history for those with stable housing compared to those without. Notably, decedents with unstable housing were more likely to have sought treatment: 42.9% of individuals who had previously sought treatment had stable housing, compared to 57.1% of individuals who did not. A further evaluation highlighted significant differences in what type of treatment individuals with unstable housing accessed. Individuals with unstable housing were significantly more likely to attend outpatient programs, inpatient programs, counseling services, detoxification centers, and sober living programs. Prior research has noted the direct links between unstable housing and SUD, signifying two approaches to helping this unique population: Housing First (HF) models and Treatment First (TF) models. HF models focus on providing unstably housed individuals with safe and secure housing first and foremost, without tying residency to abstinence requirements, while TF models only provide individuals with housing if they maintain total abstinence and meet certain program requirements.

Research also makes clear to us that unaddressed and untreated trauma can spiderweb out from those traumatized into relationships with family, friends, children, colleagues, and the community as whole. Ray Flannery, Jr., PhD, Associate Clinical Professor of Psychology at

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Harvard Medical School speaks to this directly. He states that, "The victim may experience disruptions in the domains of reasonable mastery of the environment, caring attachments to others, and a sense of meaningful purpose in life as well as the symptoms associated with traumatic events, especially hypervigilance, exaggerated startle response, intrusive memories, and a desire to withdraw from routine activities."[4] While we do not have specific data around the number of non-fatal overdoses occurring in the communities, as some go unreported and without medical intervention, there is potential that it continues to have a ripple effect among hundreds of families annually.

Many individuals that experience trauma turn to drugs and alcohol to self-medicate. Many individuals that experience trauma are not equipped to process the trauma, nor do they know where to receive the help that they need. This is clear. It is on us now, to ensure we treat the individual specifically, rather than just their addiction.

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