The 5-Step Method and Trauma[1]

Contents

Introduction

In recent years there has been an increasing awareness of trauma in the wider mental health field. Through this awareness has come a growing recognition that trauma is a significant mental health difficulty that can have serious, often long-term adverse effects, as well as a recognition that workers can re-traumatise the people they support, typically without being aware of doing so. This can lead to unnecessary distress, that serves no therapeutic benefit, and as a consequence the potential premature withdrawal from support.

Experience with the 5-Step Method, particularly in the context of bereavement through alcohol and other drug-use or gambling, has indicated the need to consider the role of trauma for all Affected Family Members (AFMs). AFMs can experience a range of traumas associated with the alcohol, other drug or gambling behaviours of someone else, as well as potentially being traumatised in other ways.

It is important to emphasise that **the 5-Step Method is not a trauma intervention**. Most practitioners using the intervention with AFMs will not have completed specialist training, or be otherwise experienced, in the area of trauma, and you need to tell AFM clients that this is the case where applicable. However, we consider that it is helpful for you to have a basic understanding of trauma in the context of this work, have an overview of the common signs and symptoms of trauma, to ask about possible trauma during an assessment, and to have a way to help an AFM who has become re-traumatised during their session with you.

[1]This document has been co-authored by Peter Cartwright (https://peter-cartwright.co.uk/) and Lorna Templeton (on behalf of AFINet). The contents of this document are adapted from the work of Cartwright (2020), Levine (2008), Rothschild (2000 & 2017) and van der Kolk (2014) (see the References section at the end).

The basic messages in this document will apply across the world. However, we imagine that there will be some variation in how trauma can affect AFMs, both within and between countries. There will also be variation in the training, services and other resources that are available from country to country.

Understanding trauma

The term ‘trauma’ is widely used, so it is important to define it in the context of alcohol, other drug and gambling related behaviours, and the associated impact upon AFMs: Trauma is the normal survival response that is triggered when someone’s ability to respond to a perceived inescapable threat to themselves or a loved one is in some way overwhelmed. This can result in the person re-experiencing the threat, avoidance of re-experiencing it and heightened bodily mobilisation to protect against further threat.

The following brief explanation describes how this happens. When faced with what someone perceives as a sudden, distressing or frightening threat, they are usually able to cope. Afterwards, they are able to remember the event, make sense of it, have appropriate emotions about it, and know it is in the past, and that they and any of their loved ones survived and are now safe.

However, if someone is faced with a threat that they perceive as *overwhelmingly* frightening, especially if they also perceive being unable to escape from that threat, they are highly likely to have a trauma response.

This normal survival response happens in reaction to what is an abnormal situation, and is something that is automatic and not within conscious control. The response is often very different to those following a threat that is not perceived as overwhelming: typically feeling all-consuming, confusing and frightening, and is a severe emotional shock that affects someone’s body, mind and central nervous system. Once the trauma response is switched on, it can be slow to switch off and stays ready to be restimulated by reminders of the original threat – including talking to a 5-Step Method worker about the overwhelmingly threatening event. This is *deeply unpleasant for someone who is traumatised, serves no therapeutic benefit and may result in someone prematurely ending their support or reducing the potential benefits and positive change that often accompany working through the 5-Step Method.*

It is important to remember that the 5-Step Method is not a substitute for the specialist trauma help that some AFMs will need. So, as with any other risk or safeguarding issue, you will need to respond accordingly. If a client is showing signs of trauma, then you may need to delay or stop use of the 5-Step Method, and your service should have protocols in place for responding appropriately, including discussions with managers and clinical supervisors. Your service should also have details of national and local referral options for specialist trauma support where

required. If an AFM is already receiving specialist help, or their traumatic symptoms are in the past, then you may be able to keep working with them, but you should still be alert to their symptoms and discuss with AFMs as required.

Understanding trauma in the context of alcohol, drugs and gambling behaviours

There are several ways that an AFM may be traumatised, including but not limited to:

- Through the overwhelmingly threatening behaviour towards them by someone who uses alcohol or other drugs or gambles, (e.g. domestic violence).
- Through overwhelming threats to a loved one, including the person who uses alcohol or other drugs, or gambles, (e.g. an overdose, being assaulted by someone who is a drug-dealer).
- Through other overwhelming threats that are unrelated to alcohol, other drugs or gambling. These may have occurred at any age in the AFM's life, (e.g. childhood sexual abuse, being bullied at school, or other difficult bereavements).

Given that the trauma response happens automatically and is not within conscious control, it follows that someone is typically unaware of having been traumatised. Their trauma response is often easily restimulated by continued perceived overwhelming threats associated with ongoing alcohol/other drug using or gambling behaviour, including even after the death of a loved-one, as explored further below. This restimulation is a response to what is perceived, out of awareness, as the original threat happening again. It can include talking about or recalling the memory of the traumatic event, as well as more abstract and subtle perceptions such as a sound or an object associated with the event.

Trauma and the 5-Step Method

It is important to remember that the 5-Step Method is not a trauma intervention or a substitute for the specialist trauma help that some AFMs will need. So, as with any other risk or safeguarding issue, you will need to respond accordingly. If a client is showing signs of trauma, then you may need to delay or stop use of the 5-Step Method, and your service should have protocols in place for responding appropriately, including discussions with managers and clinical supervisors. Your service should also have details of national and local referral options for specialist trauma support where required. If an AFM is already receiving specialist help, or their traumatic symptoms are in the past, then you may be able to keep working with them, but you should still be alert to their symptoms and discuss with AFMs as required.

Below is basic guidance on working with trauma.

There are a wide range of signs and symptoms to indicate that someone may be experiencing trauma, some of which overlap with symptoms of grief, stress and other difficulties, and can range from mild through to severe. These symptoms can be continual or intermittent, they may change over time, and as time goes on may be less obviously connected to the traumatising event. Common signs and symptoms include:

- Over mobilisation in the body (e.g. rapid heart rate, sweating, panic, anxiety, hyper-vigilance).
- Under mobilisation in the body (e.g. very slow heart rate, immobility, utter helplessness).
- Desensitised; numb; amnesia about the traumatic event; and/or seemingly 'gone away', as if no longer present, when with you, especially when recalling an overwhelmingly threatening event.
- Intrusive images, flashbacks, nightmares and/or disturbed sleep.
- Mood swings and extreme emotions.
- Avoidance of people, places, activities etc. that are associated with the traumatic event; withdrawal from others.
- Shame and/or guilt about actions or inaction during the traumatic event.
- Increased substance use.
- Loss of worldview and spirituality.

We suggest that you ask about *possible* trauma during an assessment, such as:

- Has an AFM been diagnosed with trauma by a health care professional.
- Does an AFM recognise themselves in one or more of the first three bullet points above.
- Has an AFM lost their sense of safety in the world.

If an AFM is suspected to have become re-traumatised *during a 5-Step Method support session, this needs to be dealt with as the priority*. If an AFM is overly distressed, or overly numb and shut-down, the following approach is suggested:

> *How does someone feel in their body when you ask them to **briefly** recall the threatening event. Look for the signs and symptoms described above. If present, work on the assumption that they have some degree of trauma, **and then ask them to switch their attention away from that 'there-and-then' memory and to being back with you 'here-and-now' in the room.** For example, ask them to look around the room that they are in and tell you about everything that is blue or is square shaped*.

Stay with this until the AFM feel calms, and their attention is fully back with you, in the room, and no longer on their memories of the past. This process safely 'grounds' them back with you (in a room, over the phone or online), so they are no longer experiencing trauma symptoms. Consider whether to continue the session, including asking the AFM whether they want to continue. However, this is just a guide. Also, whilst it is likely that the AFM is traumatised, it is not a formal diagnosis of trauma, so referral to suitable support should be discussed and actioned if possible.

Note that an AFM may still be traumatised when no signs were reported by them, or they may not be traumatised by alcohol-, other drug- or gambling-related events when they do report signs because these are actually signs of something else, such as stress or grief. Therefore, you need to be alert to the potential for trauma throughout this work.

Trauma in the context of alcohol, other drug or gambling-related bereavement

AFMs can experience trauma following the alcohol-, other drug- or gambling-related death of a loved-one. This includes and is not limited to knowing someone died a distressing death (e.g. health-related in a medical setting, suddenly such as an overdose, or due to the involvement of other parties); being present and witnessing the death; not being with someone and imagining how they died (e.g. in pain, alone, frightened); deaths by suicide; or being involved in the same event (e.g. a car crash, or using substances with the person who died); as well as after the death (e.g. a court case or insensitive media/social media attention).

The 5-Step Method has been adapted for use with AFMs bereaved following an alcohol, other drug or gambling related death. A small pilot project was completed in 2020, and a further larger pilot project is now underway in the UK[2]. The 5-Step Method Resource Hub may be updated in the future as our understanding of trauma for bereaved people, as well as its implications for the 5-Step Method, develops.

Some suggested further reading

Please note that you should explore what services and resources are available in your own country. We have made a few suggestions here for further reading.

For a more detailed explanation of trauma and further guidance on how to work with any traumatised AFM, written for support workers who do not have specialist trauma training, see Chapter 11 of Cartwright (2020).

[2] For more information on this work, please contact Lorna (LTempleton72@googlemail.com).

For a comprehensive exploration of trauma, based on much research and clinical experience, but also written in an easily accessible style, see van der Kolk (2014).

References

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