

# A Case Report about the Interrelation of Trauma, Emotional and Behavioral Response and Severe Alcohol Use Disorder

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**Abbreviations:** EMDR: Eye Movement Desensitization and Reprocessing; REBT: Rational Emotive Behavioral Therapy; HPA: Hypothalamic-Pituitary-Adrenal; PTSD: Posttraumatic Stress Disorder; EBP: Evidence-Based Practices

## ABSTRACT

**Objectives:** To understand the complexity of the client's problems with alcohol use disorder and the importance of treating the underlying reasons of trauma to assist the client toward full recovery. To identify the related factors including traumatic events and irrational beliefs that led to the client's emotional response of anger. To understand that anger, when using unhealthy coping strategies, fosters violent behavior. To comprehend that alcohol is often used as a self-medication for dealing with emotional injury, irrational beliefs, and low self-esteem.

**Method:** This case report describes the interrelation of possible etiology and emotional and behavioral responses that led to a complex mental health issue in a male client. The client's symptomology represented violent behavior toward others specified as Intermittent Explosive Disorder 312.34 (F63.81) and severe Alcohol Use Disorder 303.90 (F10.20) in early remission (DSM-5, 2013). Alcohol use is often associated with violent behavior, but it is also important assessing and treating trauma symptoms in understanding the complexity of alcohol use and domestic violence. The case report provides a framework of clinical treatment to assist the client for recovery and gaining sustained holistic wellness.

**Results:** The client showed good progression with re-processing traumatic events with Eye Movement Desensitization and Reprocessing (EMDR) therapy as well as applying Rational Emotive Behavioral Therapy (REBT) when working with irrational beliefs including identity, masculinity, and healthy behaviors.

**Conclusion:** After 6 months of follow up the client has shown positive treatment outcomes as evidenced by stability in his mental health and life.

## Introduction

We present a case of a male client who was sent to treatment because of anger and violent behavior as well as use of alcohol. Literature shows a high comorbidity of violent behavior and use of substances including alcohol [1-3]. A study by [4] found an association between alcohol dependence and violent offenses. Individuals with higher levels of anger expressions are at higher risk to relapse to violence and substance use [5]. Individuals are socially conditioned how to deal with emotions and behavioral response. Being male and obtaining an alcohol use disorder is

associated with an increased risk of being exposed to violence [6,7]. Dominant behavior is also linked to masculine norms as males are often expected to be strong, independent, and do not show emotions [8]. Research found that individuals recovered from an anger instigation easier when they used their common way of anger expression such as communication or inhibit it [9]. For example, Native American males were found to recover from anger more quickly when they inhibited it and recovered slower when instructed to express their anger [10]. Males from marginalized

populations are more likely to perceive racial discrimination as threatening and experience anger but use inhibition of anger to avoid aggressive behavior [11] which can impact levels of blood pressure [12]. Hence, this shows that cultural norms impact the socially accepted mode of response to anger. Suppressed feelings of anger have been implicated to pathophysiology of health problems [13], blood pressure [14] including cardiovascular disease [15,16]. When individuals suppress their anger, they may cumulate their emotional responses within their body and respond delayed and more intense [17]. found that inhibiting emotional information is linked with prospective changes in an increased cortisol awakening response six months later and shows how it influences the Hypothalamic-Pituitary-Adrenal axis (HPA) functioning. Anger is reflected across physical components including stress reactivity with connected autonomic arousal, hypervigilance, and hostile attributions [18]. The emotional response of anger is often expressed in violent behavior toward others and the most serious violent offenders also represent the most severe drug issues [2]. When considering clients who struggle with violent behaviors and alcohol use disorders, the clinical mental health counselor should also assess the client's trauma history. Childhood adversities are associated with early use of alcohol, which indicates high risk for alcohol use disorder in adulthood [19]. Individuals who experienced multiple adverse childhood trauma are more likely to be heavy alcohol users and males are showing a significant higher risk of violence [20]. A study by [21] investigated the correlation between drinking and trauma symptoms and found that drinking is mediating to cope with it. The results suggested the importance of assessing trauma in clients who struggle with alcohol use disorders as experienced trauma can be the etiology that leads to suppressed anger and emotional distress. The client may try to self-medicate the emotional distress with alcohol consumption which increases the risk for violent behavior. This case report provides the treatment plan based on treating re-processing trauma with EMDR including emotional catharsis, psychoeducation about emotions and coping to channel behavioral responses. The clinician considered the client's cultural background related to historical trauma that impact indigenous populations until today. In addition, the clinical mental health counselor guided the client toward implementing healthy activities toward holistic wellness.

## Case Report

### Client History

A 33-year-old male was seeking mental health counseling services after having completed detoxification and crisis management in the clinic. The client was tall, raw boned, and represented some hesitance in our first session but answered questions and appeared feeling more comfortable after the first intake counseling session. On a mental examination, the client reported symptoms of anger since he started school at age 8 years

old when his peers started bullying him because of his Native American background. He shared that he was never feeling a happy child as his family members were struggling with alcoholism, poverty, and conflicts that mostly resulted in domestic violence. The client described that he has not only witnessed violence from his father against his mother and siblings but was also exposed to physical and emotional abuse himself since he can remember. He reported that he started being physically abusive towards his peers and younger siblings at age 13 years as it made him feel being strong like his father. The client shared that he was also physically abusive toward his first girlfriend when he was 18 years old, and his romantic relationships did not last for long throughout his life.

The client shared not being in a romantic relationship and having no family support. He reported that he often felt unable to concentrate or cope and dropped out of high school and started construction work when he was 21 years that he continued at different workplaces over eight years. The client reported that he did not feel comfortable with his co-workers in general. He reported having been let go at his job because he was angry and threatening towards one of his team members. This was the time when the client increased his consumption of alcohol and got into legal issues due to driving under the influence of alcohol. The clinical mental health counselor completed a comprehensive diagnostic assessment and according to identified criteria, the client was diagnosed with Intermittent Explosive Disorder 312.34 (F63.81) and severe Alcohol Use Disorder 303.90 (F10.20) in early remission (DSM-5, 2013). The client did not meet all criteria for diagnosing Posttraumatic Stress Disorder (PTSD) but expressed that his childhood was painful. The clinical mental health counselor explored with the client the most traumatic childhood experiences and identified related belief systems of himself, others, and the world.

### Treatment Process

The treatment process was based on theory and research as clinical mental health counselors engage in scientifically based interventions. Professional counseling is both science, clinical expertise, and an art that integrates theory and practice for the benefit of the client. The client's major areas to treat were childhood trauma, emotional and behavioral responses, and alcohol use disorder. The clinical mental health counselor developed a positive working alliance with the client through empathy, authenticity, and unconditional regards and explored how his family and culture has influenced his upbringing and shaped his belief systems. A competent clinical mental health counselor conceptualizes the client through the lens of a counseling theory and integrates the best Evidence-Based Practices (EBP) to assist the client in improving mental health and overall wellness. The clinician based the case conceptualization on Rational Emotive Behavioral Therapy (REBT) that concentrates on the client's irrational beliefs and

considered the context of the client's characteristics and cultural background. Related to the client's experienced childhood traumas, the implementation of EMDR was recommended for a successful long-term treatment outcome. EMDR was originally developed by Francine Shapiro for trauma treatment in the late 1980s (Shapiro, 1989). This psychotherapeutic approach has grown as more clinicians underwent comprehensive training to learn about the origins and the theoretical underpinnings and utilizing protocols and techniques effectively. It is important to screen if this method is suitable for the client as individuals who are actively suicidal or are actively dissociating are not appropriate for immediate trauma processing failure (Shapiro, 1991). Because the client was found to be benefitting from EMDR therapy, the content for the next 6 sessions was the application of Reprocessing (EMDR) therapy for re-processing some of his recalled physical and emotional abuses by his father. The clinician prepared the client with resources including gained appropriate self-regulation skills and self-management skills such as breathing techniques and progressive muscle relaxation before focusing on trauma re-processing. The identified irrational core beliefs related to the earliest and the most intense traumatic events at age 5 were the core of the EMDR treatment.

The process was based on a three-pronged protocol that utilized past, present, and future for organizing the targets of the application. The client preferred tactile stimulation for processing the traumatic event. It was also important to consider the cognitive associations of unresolved trauma that include responsibility, safety, and choice. Once these old traumas were processed, the clinical mental health counselor targeted present life situations that were triggering guilt and urging the client to act out violently. Additional techniques such as writing and culturally appropriate rituals such as sweats were implemented to strengthen the client's recovery process and the clinician provided psychoeducation about historical trauma and how epigenetics influenced generations of indigenous populations. Providing psychoeducation about emotions and how the client can channel them into healthy behavioral responses as well as discussing characteristics of masculine norms that are constructed by society helped the client to discover more about his behavioral outbursts and violence against others. The clinician also enhanced the client's visual representation of life without addiction by using bilateral stimulation. The client identified his triggers for relapse and the clinician helped him desensitized those triggers step by step to support his recovery. Healthy coping strategies such as mindfulness techniques helped the client to promote calmness and being centered and grounded. In addition, the clinician guided the client using the traditional tribal medicine wheel for working on all four areas to gain holistic well-being. REBT assisted well to work on the client's irrational beliefs about himself, his family members, and the world. Treatment was effective in assisting the client to re-

process his past traumas, resolving his anger associated with the history of physical and emotional abuse, and preventing violent behavior and relapse to use alcohol. To conclude, the treatment helped the client to recover and rebuild his life.

## Discussion

Addiction is a worldwide concern and governments are recognizing that more care is needed to help individuals to recover and rebuild their lives. According to the United Nations of Drug and Crime 2019 report, the worldwide number of individuals who were diagnosed with substance use disorders raised from 30.5 million in 2017 to 35 million in 2019, while only one in seven receives treatment. In 2017, an estimated 271 million individuals (5.5%) of the worldwide population aged 15-64 had used drugs in the previous year [22]. Substance use problems are one of the primary issues that are linked to social and health problems in indigenous people [23]. Nevertheless, there is also a high prevalence of relapse when clients seek treatment for addiction. According to the American Addiction Centers [24] the percentage of people who will relapse after a period recovery ranges from 50% to 90%. Researchers understand alcohol-related behavior change as a process over time by identifying relapse patterns and remission factors for long-term clinical outcomes [25]. Although medication helps to detoxify individuals from drugs it cannot replace treatment [26] provided by a clinical mental health counseling is necessary to assist the client for a long-term recovery. A comprehensive examination of published articles about relapse characteristics related to alcohol use disorders identified that comorbidity, severity, craving, using other substances, and social factors are crucial for risk of relapse after remission [27]. To treat addiction effectively, the underlying issues as well as the whole person must be considered. Trauma is manifested on emotional, behavioral, and physical levels and traumatized clients are acting out past events and experiencing loss of self-worth as the individual's relationship with existence itself is shattered.

Childhood trauma was associated to significant increased health risk for alcoholism [28] and trauma that is not integrated increases sensitization and stress in the individual [29]. EMDR is a method developed to treat trauma and can be well integrated into various theoretical approaches to mental health counseling and psychotherapy. Clinicians who work with clients in the addiction field need to be trained well to deal with trauma and addiction treatment, as most clients presenting addiction have a trauma history [30]. In addition, the client's cultural background is related to historical trauma as his ancestors experienced genocide and historical oppression over generations. Providing psychoeducation about the impact of historical trauma and how the collective experience of his community has resulted in higher risk for dysfunctional families, violence, and the use of alcohol helps the

individuals to understand his internalized negative beliefs about himself. Acknowledging historical trauma in an honest and direct way enhances any relationship and is essential in the healing circle for Native Americans [31]. The memory of this collective injury and emotional and behavioral responses might be conserved at the molecular level inbuilt in epigenetic inheritance [32]. The clinical mental health counselor's overall treatment framework was based on the self-medication model that believes that individuals develop addiction to mask other underlying issues. Therefore, one of the effective ways to heal addiction is to treat the underlying problem [33]. In this case report, the client has experienced multiple traumas throughout his childhood and his emotional response of anger manifested in his violence against others. Alcohol has been part of the problem to numb the pain that was the driving force behind his anger. The treatment of these underlying issues helped to build a steady foundation for the client to recover and prevent relapse. Working with the client on emotional and behavioral responses as well as his cultural background [34] was an effective approach. The clinical mental health counselor worked with the client on his irrational beliefs about himself to enhance his self-worth with REBT therapy. In addition, the integration of physical, mental, spiritual, and relational care including walking in nature, wood gathering, sweats, and other traditional healing practices improved the client's holistic wellness and sustained sobriety.

## Conclusion

The provision of trauma treatment for a client who was meeting the DSM-5 criteria for Intermittent Explosive Disorder 312.34 (F63.81) and severe Alcohol Use Disorder 303.90 (F10.20) in early remission (DSM-5, 2013) but not for PTSD was effective in this case report and led to achieve long-term recovery. This case report highlights the importance of involving clinical mental health counselors in treating clients with both addiction and underlying issues such as traumatic events. Clinicians must consider how trauma contributes to the progress of symptoms including anger and addiction as they are often connected.

## Conflict of Interest

We have no conflicts of interest to disclose.

## Highlights

- a. EMDR was considered as an effective therapy to re-process early traumatic events that have led to anger.
- b. Using psychoeducation and culturally appropriate techniques were essential for integrating healthier responses into daily life outside of professional counseling.
- c. Applying REBT showed positive results regarding the client's holistic wellness as evidenced by improvement in physical, mental, spiritual, and social areas of his life.

## References

1. Boden JM, Fergusson DM, Horwood LJ (2012) Alcohol misuse and violent behavior: findings from a 30-year longitudinal study. *Drug and Alcohol Dependence* 122(1-2): 135-141.
2. DeLisi M, Vaughn MG, Salas-Wright C, Jennings WG (2015) Drugged and dangerous: Prevalence and variants of substance use comorbidity among seriously violent offenders in the United States. *Journal of Drug Issues* 45(3): 232-248.
3. Klostermann K, Kelley ML, Mignone T, Pusateri L, Fals-Stewart W (2010) Partner violence and substance abuse: Treatment interventions. *Aggression and Violent Behavior* 15(3): 162-166.
4. Kopac AM, Vartanian L, Hoffmann NG, Hunt DE (2014) The connections between substance dependence offense type, and offensive severity. *Journal of Drug Issues* 44(3): 291-307.
5. Oberleitner LM, Mandel DL, Easton CJ (2013) Treatment of co-occurring alcohol dependence and perpetration of intimate partner violence: The role of anger expression. *Journal of Substance Abuse Treatment* 45(3): 313-318.
6. Chermack ST, Grogan-Kaylor A, Perron BE, Murray RL, De Chavez P, et al. (2010) Violence among men and women in substance use disorder treatment: A multi-level event-based analysis. *Drug and Alcohol Dependence* 112(3): 194-200.
7. Murphy S, Kruse M, Elklit A, Brink O (2019) Risk factors for violence-related injuries in emergency departments: A Danish linkage study. *European Journal of Psychotraumatology* 10(1): 1606627.
8. Lindinger-Sternart S (2015) Help-seeking behaviors of men for mental health and the impact of diverse cultural backgrounds. *International Journal of Social Science Studies* 3(1): 1-6.
9. Engebretson TO, Matthews KA, Scheier MF (1989) Relations between anger expression and cardiovascular reactivity: reconciling inconsistent findings through a matching hypothesis. *Journal of Personality and Social Psychology* 57(3): 513-521.
10. Suchday S, Larkin KT (2004) Psychophysiological responses to anger provocation among Asian Indian and White men. *International Journal of Behavioral Medicine* 11(2): 71-80.
11. Barefoot JC, Peterson BL, Dahlstrom WG, Siegler IC, Anderson NB, et al. (1991) Hostility patterns and health implications: Correlates of the Cook-Medley Hostility Scale scores in a national survey. *Health Psychology* 10(1): 18-24.
12. Steffen PR, Mc Neilly M, Anderson NB, Sherwood A (2003) Effects of perceived racism and anger inhibition on ambulatory blood pressure in African Americans. *Psychosomatic Medicine* 65(5): 746-750.
13. Harburg E, Julius M, Kaciroti N, Gleiberman L, Schork AM (2003) Expressive/suppressive anger-coping responses, gender, and types of mortality: a 17-year follow-up (Tecumseh, Michigan, 1971-1988). *Psychosomatic Medicine* 65(4): 588-597.
14. Harburg E, Erfurt JC, Hauenstein LS, Chape C, Schull WJ, et al. (1995) Socio-ecological stress, suppressed hostility, skin color, and black-white male blood pressure. *Toward an Integrated Medicine: Classics from Psychosomatic Medicine* 245: 1959-1979.
15. Alexander F (1939) Emotional factors in essential hypertension. *Psychosomatic Medicine* 1(1): 175-179.
16. Jorgensen RS, Johnson BT, Kolodziej ME, Schreer GE (1996) Elevated blood pressure and personality. A meta-analytic review. *Psychological Bulletin* 120(2): 293-320.
17. Wong SF, Trespalacios F, Ellenbogen MA (2020) Poor inhibition of personally-relevant facial expressions of sadness and anger predicts an elevated cortisol response following awakening six months later. *International Journal of Psychophysiology* 150: 73-82.

18. Fink G (2016) Stress: Concepts, Cognition, Emotion, and Behavior (Edn.), Handbook of Stress Series, Volume 1 (Vol 1). Academic Press.
19. Ramos-Olazagasti M, Bird H, Canino GJ, Duarte CS (2017) Childhood adversity and early initiation of alcohol use in two representative samples of Puerto Rican youth. *Journal of Youth and Adolescence* 46(1): 28-44.
20. Bellis MA, Hughes K, Ford K, Edwards S, Sharples O, et al. (2018). Does adult alcohol consumption combine with adverse childhood experiences to increase involvement in violence in men and women? A cross-sectional study in England and Wales. *BMJ Open* 8(12): e020591.
21. Kaysen D, Dillworth TM, Simpson T, Waldrop A, Larimer ME, et al. (2007) Domestic violence and alcohol use: Trauma-related symptoms and motives for drinking. *Addictive Behaviors* 32(6): 1272-1283.
22. (2019) United Nations of Drug and Crime [UNODC]. World Drug Report 2019.
23. (2020) World Health Organization [WHO] Management of substance abuse: Indigenous peoples and substance abuse.
24. (2021) American Addiction Centers. Beating the Relapse Statistics.
25. Maisto SA, Hallgren KA, Roos CR, Witkiewitz K (2018) Course of remission from and relapse to heavy drinking following outpatient treatment of alcohol use disorder. *Drug and Alcohol Dependence* 187: 319-326.
26. (2020) NIDA. Treatment and Recovery.
27. Sliedrecht W, De Waart R, Witkiewitz K, Roozen HG (2019) Alcohol use disorder relapse factors: A systematic review. *Psychiatry Research* 278: 97-115.
28. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, et al. (2019) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine* 14(4): 245-258.
29. In: Van der Kolk BA, McFarlane AC (Eds.), (1996) Traumatic stress: The effects of overwhelming experience on mind, body, and society. Guilford Press.
30. McCauley JL, Killeen T, Gros DF, Brady KT, Back SE (2012) Posttraumatic stress disorder and co-occurring substance use disorders: Advances in assessment and treatment. *Clinical Psychology: Science and Practice* 19(3): 283-304.
31. Duran E (2006) Healing the soul wound: Counseling with American Indians and other Native people. Teachers College Press.
32. Galler J, Rabinowitz DG (2014) Chapter seven-the intergenerational effects of early adversity. *Progress in Molecular Biology and Translational Science* 128: 177-198.
33. Khantzian EJ, Albanese MJ (2008) Understanding addiction as self-medication: Finding hope behind the pain. Rowman & Littlefield Publishers.
34. Hardy A, Brown-Rice K (2016) Violence and residual associations among Native Americans living on tribal lands. *Professional Counselor* 6(4): 328-343.

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