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A PSYCHODYNAMIC EXPLORATION OF THE LINK BETWEEN CHILDHOOD TRAUMA AND LATER ADDICTION

THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE HIGHER DIPLOMA IN COUSELLING AND PSYCHOTHERAPY

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MAY 2020

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ACKNOWLEDGEMENTS

My sincere and grateful thanks go to:

Dr. Grainne Donohue for her guidance on writing a research proposal and minor dissertation.

Monica Errity, my supervisor, for her patience, support and guidance throughout the process.

My classmates for their support and openness in the learning process over the past two years.

My friends, with a special thanks to Leah Hamill for her practical support as well as just being a great friend!

And to my family – Jay, James and my Mum Sheelagh - for their continued support, patience and encouragement over the past two years.

ABSTRACT

Addiction or substance use disorder is prevalent both nationally and globally and has been throughout history and across cultures. There are numerous theories of addiction including the moral theory, disease theory, genetic theory and psychological theory, along with many others. This essay explores the connection between childhood trauma and later addictions from a psychodynamic perspective and seeks to understand the importance of the link for the psychotherapeutic practitioner. Addiction is discussed in conjunction with certain psychoanalytic ideas, complex post-traumatic stress disorder and other stress disorders, attachment theory, the Adverse Childhood Experience study and early developmental processes. The link between childhood trauma and addiction is discussed as having a significant place for the therapist especially in finding the most effective and healing therapeutic path for a client.

CHAPTER ONE: INTRODUCTION

Clinical theorists have developed sociocultural, psychological and biological explanations for why people develop addictions (Comer, 2018). This paper seeks to explore the link between childhood trauma or Adverse Childhood Experiences (ACEs) and addictions, and the importance of the link for the psychotherapeutic practitioner. Chapter one will discuss the notion of nachträglichkeit, a Freudian concept whereby an initial event becomes traumatic for an individual at a separate point in time in the future, usually triggered by a second event which provides a new understanding of the primary event (Bistoen, Vanheule, & Craps, 2014). The first chapter will consider the link between nachträglichkeit and complex post-traumatic stress disorder/PTSD addressing the fact that symptoms of PTSD may develop months and even years after the traumatic event has taken place. Complex-PTSD refers specifically to PTSD diagnosed in adults or children who have repeatedly experienced traumatic events. These could be violence, neglect or abuse. This essay will refer to PTSD (meaning to include complex-PTSD under the term) as an example of a current symptom linked to past trauma.

PTSD has been widely linked to substance misuse (Love, 2018) (Garland, 2012) (Van Der Kolk, 2015) (Comer & Comer, 2018) (Morgan, 2019) (Brown & Wolfe, 1994). This connection will be considered along with some of the definitions of addiction and ideas that define addiction.

Chapter two will discuss the impact the different types of stress have on the child's developing brain and will look at the classic Vietnam Veteran Study 1971 (Becona, 2018) which illustrates the part stress can play in substance misuse (Maté, 2018, p. 138). The infant is born available and ready for connection with another. Attachment plays a key role in the formation of neural pathways which in turn can play a part in an individual's sensitivity to stressors throughout their life. Vincent Felitti's seminal ACE study established strong, graded relationships between ACEs and later negative health including addictive behaviours (Brown, et al., 2009). Chapter

two will discuss the ACE study and its findings in relation to addiction and will go on to address the importance of this link for the psychotherapist when sitting with clients. Knowledge around certain therapeutic approaches including attachment sensitive therapy and some somatic approaches will be discussed, keeping in mind that the aim of the therapist is to facilitate each client by finding the most suitable therapeutic approach tailored to their own individual needs based on their personal experience.

CHAPTER TWO: NACHTRÄGLICHKEIT: TRAUMA AS A DELAYED RESPONSE

The notion of nachträglichkeit was primarily elaborated through Freud's work on psychological trauma (Bistoen, Vanheule, & Craps, 2014). The word itself is a neologism coined by Freud which has been translated as: deferred action, après-coup, afterwardness, retroactive temporality, belatedness, latency and retrospective attribution. These translations are limiting and generally emphasise only one aspect of the far-reaching implications of this construct. Freud's work on trauma is deeply intertwined with his study of hysteria – he developed his theories of psychological trauma and hysteria simultaneously. The concept of nachträglichkeit is central to the psychoanalytical understanding of trauma (Bistoen, Vanheule, & Craps, 2014). Essential to this notion is that an initial event only becomes traumatic, in the sense of exerting its full pathogenic power, at a later stage in psychical development, when the initial event to which the subject was unable to react adequately is revived by a subsequent encounter (Bistoen, Vanheule, & Craps, 2014). It thus refers to the process by which pathology develops following a trauma that is constituted by two etiological moments instead of just one (Mather & Marsden, 2004).

Freud was convinced that patients with hysteria suffered from psychological traumata that had not been sufficiently abreacted (Freud S. , 1975, pp. 27-39). He found that each hysterical symptom was due to a psychic trauma reviving an earlier traumatic event (Bistoen, Vanheule, & Craps, 2014). In the *Project for a Scientific Psychology* (Freud S. , 1975, pp. 283–397) there is a description of the case of Emma which Bisteon, Vanheule & Craps use in order to clarify the notion of nachträglichkeit. Emma, a 27 year old Viennese woman (treated by Freud from 1892 – 1895) had a compulsion not to be able to enter shops alone. To explain her symptom Emma reveals that aged 12 years old she entered a shop where she saw two shopkeepers laughing at her and she ran away in some sort of affect of fright. Emma remembered the shop keepers laughing at her clothes and that one of them "had pleased her sexually" (Freud S. ,

1975, p. 353). Freud concluded that this memory explained neither the compulsion nor the determination of the symptom (Bistoen, Vanheule, & Craps, 2014). A second memory chronologically prior to the first, when Emma was eight years old is revealed: on two occasions when Emma entered a shop to buy sweets the shopkeeper had grabbed at her genitals through her clothes (Freud S. , 1975, p. 354). Freud concluded that the laughing shopkeepers when Emma was 12 had unconsciously activated the older scene through the evocation of the grin with which the shopkeeper had accompanied his assault. This reviving of the older scene "aroused what was certainly not able at the time, a sexual release, which was transformed into anxiety." (Freud S. , 1975, p. 354). Freud assumes the changes of puberty bring with them a different understanding of the original scene. In 1986 Freud claimed that "the ultimate cause of hysteria is always the seduction of a child by an adult" (Freud & Breuer, 1962). Nachträglichkeit refers to a mechanism that literally alters the subjective interpretation of the past, in such a way that this altered memory causes new and unexpected effects in the present (Bistoen, Vanheule, & Craps, 2014).

Bisteon, Vanheule and Craps (2014) link the idea of nachträglichkeit directly to that of delayed onset PTSD. They refer to the paper *Delayed-onset PTSD among war veterans: the role of life events throughout the life cycle* (Horesh, Solomon, Zerach, & Ein-Dor, 2011) outlining that the belated onset of traumatic pathology does not occur at a random moment in time but is logically determined. The symptoms of PTSD may develop shortly after the event, but may also develop months and even years after it, in fact, 25% of people with PTSD do not develop a full clinical syndrome until six months or more after their trauma (Comer & Comer, 2018). Research suggests that it is not the traumatic experience by itself that drives the development of PTSD but intrusive and distressing recollections or memories of the trauma (Morgan, 2019, p. 144). Recent studies point in the same direction as they emphasize the importance of life events in

precipitating delayed-onset PTSD. In particular, life events that are reminiscent of an original stressful experience might "activate and unmask latent psychopathology" (Horesh, Solomon, Zerach, & Ein-Dor, 2011, p. 864).

The association between PTSD and substance use is well-established in existing literature (Love, 2018) (Comer & Comer, 2018, p. 158) (APA, 2013). Approximately one third to one half of severely traumatized people develop substance abuse problems (Van Der Kolk, 2015, p. 329). Adults diagnosed with post-traumatic stress disorder exhibit substantially higher rates of substance abuse and dependence than persons without PTSD (Garland, 2012). Investigations examining comorbidity among patients seeking substance abuse treatment reveal that PTSD is a common comorbid diagnosis (Brown & Wolfe, 1994).

Bessel Van Der Kolk (Van Der Kolk, 2015) describes working with Vietnam veterans at the Boston Veterans Administration Clinic who were withdrawn and detached, overcome by a sense of futility and unable to connect to or engage in their lives which had once been productive and well-functioning. His patients, when faced with even minor life frustrations, would fly into extreme rages and many turned to alcohol, drugs or dangerous behaviour as escapism. Van Der Kolk on hearing what these men had experienced and witnessed when at war asks if it is any wonder that traumatised individuals cannot tolerate remembering and that they often resort to using drugs, alcohol, or self-mutilation to block out their unbearable knowledge (Van Der Kolk, 2015, p. 12).

Brown and Wolfe outline that the self-medication hypothesis is commonly drawn upon in dual-diagnosis literature. When referring to PTSD as comorbid with a substance use disorder the literature postulates that PTSD develops first and that substances are subsequently used as symptom relief (Brown & Wolfe, 1994, p. 52). Oliver Morgan points out that trauma (and

PTSD) and addiction (SUDs) are often seen as co-occuring and that there are symptoms of stress and high rates of post-traumatic stress disorder among those seeking help for addictive disorders. He states that it can be difficult to obtain accurate and agreed upon statistics around exposure to trauma, but that it is beyond dispute that 30 – 50 percent of those in treatment for substance use disorder meet the criteria for lifetime PTSD (Morgan, 2019, pp. 134, 136 & 179).

PTSD is on the severe end of outcomes from toxic or traumatic exposure in people's lives. According to Morgan there are varieties of stress-related trauma spectrum disorders including depression, anxiety, somatic disorders, substance use disorders, medical disorders and also acute stress disorder and posttraumatic stress disorder (Morgan, 2019, p. 137). The DSM V outlines very specific criteria that must apply for the diagnosis of PTSD to be made, based around exposure to actual or threatened death, serious injury or sexual violence and with symptoms persisting for longer than a month. The DSM V recognises that symptoms of PTSD may begin shortly after the traumatic event or may take months or even years to manifest (APA, 2013). The DSM does not leave room for subjective causes of PTSD. Comer and Comer point out that any traumatic event can trigger a stress disorder, but that some such as combat, disasters, accidents, abuse and victimization are particularly likely to do so (Comer & Comer, 2018, pp. 159 - 163).

The essential feature of substance use disorder as per the DSM V is a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. The DSM V gives 11 diagnostic criteria which are used to diagnose the severity of a case, seeing addiction as a syndrome which presents at varying levels (from mild to severe) (APA, 2013). Robert West and Jamie Brown define addiction as "a chronic condition in which there is a repeated powerful motivation to

engage in a rewarding behavior, acquired as a result of engaging in that behavior, that has significant potential for unintended harm." West and Brown chose not to include the idea of impaired control or compulsion in their definition as it implies a weakening of self-control rather than an increase in drive to engage in the addictive behavior (West & Brown , 2013, pp. 15-18). This promotes the idea of addiction as a human adaptation whereby the substance or behaviour is solving or curing something for the individual. Dr Gabor Maté argues that all behaviours of addiction, substance-dependent or not, whether to gambling, sex, the internet or cocaine – either soothe pain directly or distract from it. Far more than a quest for pleasure, he argues, chronic substance use is the addict's attempt to escape distress. Hence Maté asks not "Why the addiction?", but "Why the pain?" (Maté, 2018, p. XIX). Maté quotes Bruce Alexander: "Even the most harmful of addictions serve a vital adaptive function for dislocated individuals" (Alexander, 2008).

There are certain forms of satisfaction that are not based on the reduction of tension and avoidance of pain. Rik Loose speaks about addiction in terms of jouissance in his book The Subject of Addiction (Loose, 2002). He addresses the idea of the toxomaniac's quest for pleasure. Jouissance can be defined in relation to the Freudian concept of pleasure. Pleasure according to Freud, is the reduction of tension to an agreeable level – the pleasure principle. Pleasure is regarded by Lacan as a very specific form of jouissance – which he termed "phallic jouissance". The word jouissance can usually be taken to refer to the realm which Freud situated beyond the pleasure principle. This is the realm of the death drive, which expresses itself in the form of negative therapeutic reactions – it is harmful and disturbing, yet one is hooked into it by one's symptoms (Loose, 2002, pp. 174-175).

CHAPTER THREE: ADDICTION: A DELAYED RESPONSE?

Psychodynamic theorists believe that people with substance use disorders have powerful dependency needs that can be traced to their early years…when parents fail to satisfy a young child's need for nurturance, the child is likely to grow up trying to find the nurturance that was lacking during the early years (Comer & Comer, 2018, p. 365). Hilary Franke outlines that healthy brain architecture relies on responsive caregivers and positive relationships to help children learn to handle stressful experiences. The stress response is a physiologic response (also known as fight/flight/freeze response) to an adverse event, demanding circumstance, stress or perceived stress. This physiologic stress response is a result of stimulation of the sympathetic nervous system resulting in neuro-endocrine-immune responses, with physiologic effects that include an increase in respiration, heart rate, blood pressure, and overall oxygen consumption. The physiologic changes associated with the stress response are usually transient, with the body returning to its baseline state when the stressor is removed. Franke identifies three types of stress that children can experience. Positive stress, which is essential for development, manifests as an infrequent, mild and short-lived situation through which the child is supported and nurtured. The child gains motivation and resilience from positive stress, and the biochemical reactions that occur return to baseline. Tolerable stress which is more severe and sustained and takes a greater toll on the body. The brain and organs recover fully from tolerable stress given the condition that the child is protected with responsive relationships and strong social and emotional support. Finally toxic stress, which results in prolonged activation of the stress response, with a failure of the body to recover fully. It differs from a normal stress response in that there is a lack of caregiver support, reassurance, or emotional attachments. Examples of toxic stress include abuse, neglect, extreme poverty, violence, household dysfunction, and food scarcity. Caretakers with substance abuse or mental health conditions also predispose a child to a toxic stress response i.e. Adverse Childhood

Experiences (ACEs). Children who experience early life toxic stress are at risk of long-term adverse health effects that may not manifest until adulthood (Franke, 2014).

The part that stress plays in substance abuse is illustrated clearly in the Vietnam Veteran Study 1971 which saw 15% of returning Vietnam soldiers meeting the criteria for a diagnosis of addiction to heroin. It was a well-known fact that throughout the Vietnam War, soldiers who had gone to Vietnam with no addiction issues, were using heroin while they were posted in South East Asia (Becona, 2018). On returning home from the war, the remission rate was 95%. These results suggested that the addiction did not arise from the heroin itself but from the needs of the men who used the drug (Maté, 2018, p. 134). Variables like being away from home in a hostile environment, at war, in a combat situation the reason for which was unclear to the soldiers, thousands of miles from home, surrounded by death, anxiousness, fear and helplessness - all contributed to the need these soldiers had to find relief in a readily available substance which worked in providing comfort and calm in their daily situation. This need to relieve the extreme stress of everyday life in Vietnam disappeared for most of the soldiers when they returned home to the support of their loved ones (Becona, 2018). Maté points out that unlike previous wars, the Vietnam War quickly lost meaning for those ordered to fight and die so far from home. This lack of meaning was a major source of stress which triggered their "flight to oblivion" - their temporary need for the relief heroin provided (Maté, 2018, p. 138).

John Bowlby believed psychoanalytic thinking would be enhanced through detailed empirical observation of infant-caretaker relationships and comparison with studies around the same relationships across the animal kingdom. Attachment today is studied in tandem with neuroscience (Morgan, 2019, p. 103). The brain's neural wiring matures through interactions with caregivers. The infant is born available and ready for connection with another.

Attachment shapes the architecture of the developing brain and psycho-emotional systems. Through secure attachment to attentive caregivers infants learn to self-regulate and develop a sense of trust in the world. Our neural machinery expects attachments and interactions with caregivers and without them, or with abusive, traumatic or neglectful interactions, a troubled future becomes more likely. (Morgan, 2019, p. 99) Alan Shore focuses on "affect regulation" as an essential achievement of the last trimester of pregnancy through to the end of the first two years of life. Regulation is the capacity to tolerate stress and modify intense emotions. Affect is a psychological and embodied response to a stimulus. Affect regulation allows the individual respond in healthy ways as opposed to over-reaction, under-reaction, substance abuse or dissociation. Three quarters of human brain growth happens outside the womb and by three years old the brain is 90 per cent of adult size. Nurturing brain development in the first years of life is crucial. Shore points out that many addicts may be vulnerable by the time they are only a few years old. The attachment relationship directly influences the genetic programming at work – which genes come into play, the timing, strength and sequencing of their involvement - the process is epigenetic (Morgan, 2019, pp. 123-125). Gabor Maté agrees, explaining that of the three conditions absolutely essential to optimal brain development (nutrition, physical security and consistent emotional nurturing), in the western world (bar cases of extreme neglect and poverty) the prime necessity of emotional nurture is the one most likely to be disrupted. He illustrates the point that emotional nurturance is an absolute requirement for healthy neurobiological brain development and quotes Daniel Siegal "human connections create neuronal connections". In those first years of life neurons, synapses and circuits that help the brain adapt to its particular environment are selected and others are discarded (Maté, 2018, p. 185).

Maté also points out that sensory stimulation from the primary parental figure has a long term positive effect on offspring's brain chemistry. Sensory stimulation is so necessary for humans

that a baby who was never picked up would stress itself to death. Premature babies in incubators have faster brain growth if they are stroked for just 10 minutes per day. Parental nurturing determines the levels of key brain chemicals including serotonin, oxytocin and neurotransmitters such as norepinephrine. Even slight imbalances of these chemicals increase individual's sensitivity to stressors for a lifetime (Maté, 2018, pp. 189 - 191).

Rik Loose outlines that in the process of the Oedipus Complex the child has to lose the person who is closest and dearest to him in order to gain access to the domain of human sexuality and desire (Loose, 2002, p. 50). In the period before castration - before sexualization of the body takes place - the infant is a passive object for the Other. This Other is the one who has taken it upon herself to look after and take care of the infant. The infant soaks up the jouissance of the (m)Other, the (m)Other evoking and establishing a jouissance in the body of the infant, in the form of drives, causing a non-sexual jouissance of the body. The way in which the infant soaks up the jouissance of the Other is dependent on how the desire of the Other is structured by fantasy. It is clear, Loose states, that the fantasy structure of the Other has important consequences, especially for the relationship of human subjects to their body (Loose, 2002, pp. 177-178).

Adverse Childhood Experience (ACE) research by Dr. Vincent Felitti was a landmark study of over seventeen thousand middle-class Americans. The study found a graded relationship between the number of categories of adverse childhood experience exposures and of each of the adult health risk behaviours and diseases that were studied. Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4 – 12 fold increased health risks for alcoholism, drug abuse, depression and suicide, 2 – 4 fold increase in smoking and poor self-related health and 1.4 – 1.6 increase in physical inactivity and severe obesity (Felitti, et al., 1998). Felitti noted that "traumatic experiences are

often lost in time and concealed by shame, secrecy and social taboo" but the ACE study revealed that the impact of trauma pervaded these patients' adults lives (Van Der Kolk, 2015, p. 148). The ACE research group concluded that adaptations such as smoking, drinking, eating and drugs although having long term health risks may be personally beneficial in the short term. Patients continually discuss the benefits of their own particular addiction. The study highlighted the idea of the problem being the solution or the presenting problem being the marker for the real problem which lies buried in time, shame, secrecy and even amnesia (Van Der Kolk, 2015, p. 150). "The basic cause of addiction is pre-dominantly experience-dependent during childhood, and not substance-dependent." (Felitti, 2003).

It is essential to note that not every person who endures adverse childhood experiences or complex trauma develops an addiction (of any sort) in their lifetime (Maté, 2018) (Van Der Kolk, 2015) (Comer & Comer, 2018). Maté does point out however, that every client in his Vancouver Clinic endured adverse childhood experiences, clarifying that the men mainly experienced neglect and physical abuse as children and that *all* the women attending his clinic had been sexually assaulted or raped at some point.

It is of the utmost importance that therapists and counsellors are aware of how stressors and trauma created by ACEs can result in long-term medical, mental health and behavioral implications for survivors. An awareness around the life-altering implications of ACEs is imperative. Unfortunately, this topic has not been explored in depth within the humanistic literature. The presence of ACEs, as defined by the trauma and medical research fields, is a widespread issue that counseling practitioners in schools, clinics, and hospitals will encounter. Knowing about ACEs allows counselors to respond in informed and clinically appropriate ways (Zyromski, et al., 2018).

In concluding his psychoanalytic paper on Addiction, Charles Melman asks what the therapist can do for the addict. He states that the real problems begin when an addict stops taking the drug. Reality for the addict can be sad and grey – made up of semblances and appearances. He suggests that the therapist must be active and present by understanding why the addict might turn to drugs as a way of treating the depressive situation that we live in (Melman, 1999, p. 7). When a client presents to a therapist with an addiction or substance use disorder or if a client is in recovery it is very useful to understand that it is perhaps likely the client may have also suffered some sort of trauma somewhere in their life. Oliver Morgan suggests attachment-sensitive counseling in response to addiction and early trauma. He argues that abstinence is not the opposite of addiction but that connection with others is. A counseling approach that begins with a welcoming relationship and has the tools for soothing the reactivity of stress and implementing safety systems is important. Attachment sensitive therapy aims to echo the characteristics of a successful primary attachment relationship to create a relationship that the client can use to begin to reconnect in the world. Morgan recommends fundamentals of a Rogerian nature for attachment sensitive therapy – warmth, openness, empathy and acceptance (Morgan, 2019, p. 30). Traumatized human beings recover in the context of relationships (Van Der Kolk, 2015, p. 212). Therapists can keep this in mind not only for their own relationship with their clients but also for the facilitation and encouragement of their clients to reconnect with families, loved ones, 12 step groups, drug rehabilitation centres and support groups. Relationships in all these contexts provide physical and emotional safety including safety from feeling shamed, judged or criticized and these relationships aid the ability of the individual to tolerate and process the reality of what they have been through (Van Der Kolk, 2015, p. 212). According to Betty Ford recovery from addiction is more than sobriety or cessation from drug use; it is multi-dimensional and encompasses health, well-being and social engagement (Morgan, 2019, p. 191). Therapists can work with clients in the knowledge that recovery is

about more than the removal of a substance or behavior from a life that is otherwise unchanged. It is change and reconnection that aids long term recovery. Gabor Maté writes that the only way those with addictions can escape is if their pain is alleviated and their emotions brought back towards a healthy balance. He quotes Dr Jaak Panksepp "Free choice only comes from thinking, it does not come from emotions. It emerges from the capacity to think about your emotions." The treatment of addiction requires the physical and mental headspace where a need to soothe pain does not constantly drive a person's motivation. It requires a supportive social environment. (Maté, 2018, p. 299).

With knowledge around the connection between ACEs and addiction, when working with a person presenting with one or both, therapists should take into account the research and opinions of Babette Rothschild, Peter Levine and Pat Ogden all of whom advocate for the use of the body as a main tool in the treatment of trauma. Connecting the person to their body in the here and now and facilitating the person's ability to connect to their own body is recognized as of the utmost importance in trauma therapy. According to Babette Rothschild trauma is a psychophysical experience even when the traumatic event causes no direct bodily harm. Understanding how the brain and body process, remember and perpetuate traumatic events holds many keys to the treatment of the traumatized body and mind (Rothschild, 2000, p. 5). These therapists and thinkers believe that trauma is held physically in the body and that work with the physical body can help release and heal the recurring symptoms of trauma. Rothschild is especially mindful of working with the body as a safety tool when therapist and client are beginning to work with traumatic past events. She advocates for understanding the body's signs of hyper and hypo arousal as markers to start "applying the brakes" so that a client's trauma does not become reactivated physically and also emotionally (Rothschild, 2017). As referred to earlier the symptoms of PTSD can start or be triggered months and even years after

the initial event. Emma, Freud's young client, felt her reaction to the shopkeeper's laughing in her body, "running away in some sort of affect of fright" (Freud S. , 1975, p. 353). Nearly 20 years later Emma was still unable to enter a shop alone, her body and mind was still feeling the affect of a traumatic incident she had been too young to understand or process at the time of its occurrence. Freud's conviction that patients with hysteria suffered from psychological traumata that had not been sufficiently abreacted directly links to the connection between adverse childhood experiences and later pathologies including substance misuse and addictive behaviours. Freud saw in a narcotics a means of coping with pain and disillusionment, keeping misery at a distance. After experimentation and work with the narcotic cocaine, he saw the decisive factor regarding the effect of the drug as something in the psyche of the user - meaning that for Freud, the cause of the addiction is to be sought within the subject and not in the drug (Loose, 2002).

CHAPTER FOUR: CONCLUSION

A pathway interconnecting Freud's original idea of nachträglichkeit, post-traumatic stress disorder and other stress disorders, adverse childhood experiences, attachment, neural programming, jouissance and addiction has been explored over the course of the two chapters of this essay. Although theories and clinical knowledge have advanced considerably since Freud's era, the idea of nachträglichkeit echoes through today's understanding of trauma, and makes for an interesting starter block when considering addiction as a pathology triggered by early trauma or adverse childhood experiences.

Certain addiction theories would have included the idea of weakened control on the part of the individual, but this essay explored the thinking that addiction should be recognized as a survival adaptation. An adaptation that takes place on a physical and even epigenetic level, meaning the individual can become more susceptible to addiction by only a few years into their life. If trauma is psychophysical, then the physical side must be addressed therapeutically along with the cognitive and emotional sides. Understanding how the brain and body process, remember and perpetuate traumatic events holds many keys to the treatment of the traumatized body and mind (Rothschild, 2000, p. 5).

To understand the addicted individual, and more importantly for the therapist, to empathise with the addicted person, the recognition that the addiction may be a survival mechanism, a symptom of the true underlying issue, could be key to the therapist being able to truly empathise and hence being able to facilitate growth and change for the client.

If connection and social support are a key part of recovery, therapists can feel grounded in their knowledge and help find the most healing path for each specific individual that they work with. Connection within the therapeutic relationship by means of attachment based therapy or even just use of the Carl Rogers' basic core conditions and also connection in groups outside the therapeutic relationship which provide support and understanding for the individual, will aid

the long term change on levels of health, social-engagement and well-being. For the practicing psychotherapist insights into the link between certain psychoanalytic ideas, adverse childhood experiences and later addiction should be recognised and kept in mind.

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