

## **A Trauma Informed Approach to SSI/SSDI Benefits Advocacy Materials Prepared for the NYSBA 2018 Partnership Conference**

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### **Introduction**

Childhood and adult trauma exposure is extremely pervasive and significantly impacts the lives of persons that you will have contact with if you practice in Social Security Disability law. While you may think of trauma exposure only when confronted with a claimant who self-reports a diagnosis of PTSD or more generally as a consequence of war or natural disaster, over the last 20 years it has been increasingly recognized that trauma includes a wide range of situations with far reaching mental, physical, behavioral and functional effects. In disability law practice we work with people with chronic medical conditions such as heart disease, diabetes, COPD and arthritis and people with depression, bipolar disorder and psychotic disorders, cognitive impairments and substance use disorders. Research tells us that these conditions may be related to trauma exposure, and/or may manifest with more severe symptoms due to trauma, and/or may be more persistent, complicated and intractable when they are grounded in trauma.<sup>1</sup> Thus, a history of trauma is legally relevant to disability claims—when present, it increases the likelihood of severe medical impairments and it often contributes to the persistence, complexity and disabling effects of physical, mental and behavioral health conditions. Understanding how trauma affects child and adult health will empower you to take disability benefit cases you might otherwise shy away from, win cases you might otherwise lose, and contribute to your client's recovery.

While some clients may immediately self-report a history of trauma or have a long record of treatment for PTSD, many do not. Unfortunately, you cannot rely on medical records to document trauma and symptoms of trauma because historically it was simply not contemplated or considered relevant to a patient's health and well-being. Even in medical records of patients with serious mental illness (SMI) documentation of trauma and symptoms of trauma is exceptionally low. Research on this topic indicates it may be due to the fact that there is an overlap between symptoms of trauma and other serious mental illnesses,<sup>2</sup> that clinicians are

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<sup>1</sup> Research has shown that trauma impacts brain circuitry, aptitude for learning and retaining information, susceptibility to illness and stress, the risk of substance abuse and misuse, and the capacity to maintain healthy relationships. Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., M.P., et. Al. (1998). 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 Preventative Medicine, Volume 14, 245-258.

<sup>2</sup> The symptoms of PTSD and other mental impairments overlap and trauma related symptoms often co-exist with mood, anxiety, substance use and personality disorders. "TIP 57: Trauma-Informed Care in Behavioral Health

hesitant to ask for fear of causing distress or impairment (there is no evidence that asking provokes negative results), and the fact that many people entered the mental health system before trauma awareness.<sup>3</sup> Thus, it's common for trauma survivors to be underdiagnosed or misdiagnosed.

When trauma symptoms are ignored by medical and treatment providers or misdiagnosed as other, hard to treat mental health conditions, it can lead to inappropriate mental health treatment, including psychotropic medication. When trauma symptoms are ignored by substance abuse treatment providers, the likelihood of remission and recovery is diminished. Misdiagnosis and inappropriate treatment can result in “failure of compliance” with treatment, with attendant legal and social consequences—including the denial of federal disability benefits.

Increasingly, trauma survivors are being recognized by the formal behavioral health system as well as in public health, education and criminal justice systems. The costs of trauma and its aftermath to victims and society are being increasingly tracked and calculated. A movement for trauma-informed care has emerged to ensure that trauma is recognized and treated and that survivors are not re-victimized when they seek care. Changes have been made and programs created to promote healthy development of children and healthy behaviors in families, schools and communities that reduce the likelihood of trauma. While initial responses focused on early interventions to prevent or stop children from being exposed to adverse experiences, there are millions of adults who have been impacted by trauma and are living with its negative effects. Because of the prevalence of trauma and its well established connection to chronic health conditions and disability, the Social Security Administration and the community of Social Security disability advocates, should, to the greatest extent possible, also be trauma informed.

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Services,” *U.S. Department of Health and Human Services*, (2014): <https://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf>. DSM-5 at 265.

<sup>3</sup> Maria Mauritz et al. “Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness,” *European Journal of Psychotraumatology* 4, no.1 (2013): doi: 10.3402/ejpt.v4i0.19985.

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## **Trauma Informed Care in Disability Law Practice**

To fully explore the impact of trauma on your clients, it is essential to create and cultivate a legal relationship that is consistent with the principles of trauma informed care (TIC). While there are a growing number of context specific definitions, TIC can generally be stated as:

“An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives”. Source: Substance Abuse and Mental Health Services Administration’s National Center for Trauma-Informed Care. Welcome to the National Center for Trauma Informed Care. <http://www.samhsa.gov/nctic>.

Integrated into social security law practice, being trauma informed means to:

- 1) Understand the varied and powerful effect of trauma on our clients’ lives, health and well-being;
- 2) Engage clients in a way that facilitates full understanding of and appreciation for our clients’ trauma histories, their current reality and their goals regarding disability benefits and recovery;
- 3) Utilize trauma awareness, science of ACEs and trauma research to better advise and represent clients and work towards more just laws and fairer application of the law.

Consistent with principles of TIC, it is important to recognize in our practice and among our clients that the experience of violence may be as witness, as victim, and as perpetrator. And, as well, not all harmful childhood experiences create behavior changes or lasting problematic symptoms. Key supports and interventions can cultivate “resilience” that provides an effective buffer to long term negative effects.<sup>4</sup> Being trauma informed when working with trauma impacted clients is therefore healthier for your clients—it reduces the likelihood that you will re-traumatize or further traumatize a client, and it can help foster and cultivate resilience in your client—something research shows is key to overcoming the negative impact of trauma.

### **I. Understanding the Effects of Adverse Childhood Experiences (ACE), Trauma, and Toxic Stress**

The Adverse Childhood Experiences (“ACEs”) Study (“ACEs”) is landmark medical research published in 1998 that first documented the connection between childhood exposure to trauma and negative adult health outcomes. The original study was conducted at Kaiser Permanente and involved two waves of data collection from over 17,000 HMO members.<sup>5</sup> The CDC continues to

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<sup>4</sup> “Resilience” is the process by which an individual moves through a traumatic event, using various protective factors for support, and is able to return to a “baseline” in terms of emotional and physiological responses to stress. For more information on fostering resilience see <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Promoting-Resilience.aspx>.

<sup>5</sup> [www.CDC.gov/violenceprevention/acestudy/about.html](http://www.CDC.gov/violenceprevention/acestudy/about.html)

assess and monitor the medical status of participants with periodic updates of morbidity and mortality data. The original ACEs Study and other studies conducted in the U.S. indicate that exposure to traumatic events are common—occurring in at least 50%-60% of the U.S. population and rates in clinical settings run much higher.<sup>6, 7</sup>

ACEs are stressful or traumatic experiences. The original study included seven categories of childhood exposure:

- physical, sexual, and emotional abuse,
- living with household members who abused substances, had mental illness or were suicidal,
- violent treatment of mother/stepmother,
- and criminal behavior in the household/imprisonment of household member.

### **Major Findings of the ACEs Study.**

The ACE score--a total sum of the different categories of ACEs reported--was used to assess cumulative childhood stress and compared to negative health and well-being outcomes across the life course. As the number of ACEs increased, so did the risk for:

- Depression, Anxiety, PTSD, Hallucinations, Suicide
- Health risk behaviors such as alcohol abuse/drug use, smoking, high risk sexual behavior,
- Physical conditions such as cardiovascular disease, diabetes, Emphysema, Cancer, obesity, skeletal fractures and liver disease.  
(suicide, heart/lung disease, diabetes and cancer are among top ten leading causes of death in US).
- Poor academic achievement, poor work performance, and financial stress.<sup>8</sup>
- People with an ACE score of 6 or higher are at risk of their lifespan being shortened by 20 years.<sup>9</sup>

And this list is not exhaustive.<sup>10</sup> The seven categories of ACEs were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life. The study also found that ACEs cluster (40% of the Kaiser sample reported 2

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<sup>6</sup> Ronald Kessler, "Posttraumatic Stress Disorder: The Burden to the Individual and to Society," *Journal of Clinical Psychiatry* 61, no. 5 (2000).

<sup>7</sup> "How Common Is PTSD," *National Center for PTSD*, (2016): <https://www.ptsd.va.gov/public/ptsd-overview/basics/how-common-is-ptsd.asp>.

<sup>8</sup> [www.cdc.gov/violenceprevention/acestudy/about.html](http://www.cdc.gov/violenceprevention/acestudy/about.html).

<sup>9</sup> "ACEs Science 101," *ACEs Too High*, (2018): <https://acestoohigh.com/aces-101/>.

<sup>10</sup> [www.cdc.gov/violenceprevention/acestudy/about.html](http://www.cdc.gov/violenceprevention/acestudy/about.html) and sources cited therein.

or more ACEs and 12.5% experienced four or more) and subsequent studies often now look at the cumulative, rather than individual effects of ACEs.<sup>11</sup> The most recent publications and applications of the Adverse Childhood Experiences (ACEs) study reiterate how adversities in childhood can have a lasting impacts on the trajectory of an individual's life.<sup>12, 13</sup> Over the past twenty years the ACEs study has been corroborated and endorsed by a dense amount of research across scientific disciplines. In addition, studies involving ACEs have demonstrated that adversities extend beyond the individual to specific populations and can even have generational effects.

## Expanded ACEs

Since the original ACEs study there has been significant research around an expanded concept of ACEs. The Philadelphia Urban ACE Task Force has been successful at demonstrating that for individuals living in poor urban communities, salient stressors such as discrimination based on race or ethnicity, witnessed community violence, and feeling unsafe in one's neighborhood are unique adversities that lead to poor life outcomes.<sup>14, 15</sup> An expanded conception of ACEs also reveals that LGBTQ individuals have a heightened risk of adverse childhood experience compared to their heterosexual peers.<sup>16</sup> When looking at the total count of ACE items sexual minorities have nearly 1.7 times the rate of adverse childhood experiences.<sup>17</sup> Unique adversities cause LGBTQ youth, particularly transgender children, to report joblessness and homelessness at a disproportionately high rate.<sup>18</sup> The higher prevalence of individual ACE items among LGB individuals creates disparities in poor mental health outcomes between this population and their heterosexual peers.<sup>19</sup> In addition, when adults with a high number of ACEs become parents

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<sup>11</sup> [www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences](http://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences).

<sup>12</sup> Namkee G. Choi et al. "Associations of adverse childhood experiences with lifetime mental and substance use disorders among men and women aged 50+ years," *International Psychogeriatric Association* 29, no. 3 (2017): <https://doi.org/10.1017/S1041610216001800>.

<sup>13</sup> Melissa T. Merrick et al. "Unpacking the impact of adverse childhood experiences on adult mental health," *Child Abuse & Neglect* 69, (2017): <https://doi.org/10.1016/j.chiabu.2017.03.016>.

<sup>14</sup> Lee Pachter et al. "Developing a Community Wide Initiative to Address Childhood Adversity and Toxic Stress: A Case Study of The Philadelphia ACE Task Force," *Academic Pediatrics* 17, no. 7 (2017): <https://doi.org/10.1016/j.acap.2017.04.012>.

<sup>15</sup> Peter F. Cronholm et al. "Adverse Childhood Experiences: Expanding the Concept of Adversity," *American Journal of Preventative Medicine* 49, no. 3 (2015): <https://doi.org/10.1016/j.amepre.2015.02.001>.

<sup>16</sup> Judith Andersen and John Blosnich, "Disparities in Adverse Childhood Experiences among Sexual Minority and Heterosexual Adults: Results from Multi-State Probability-Based Sample," *PLoS ONE* 8, no 1 (2013): e54691, doi: 10.1371/journal.pone.0054691

PMCID: PMC3553068

<sup>17</sup> Andersen and Blosnich, (2013): e54691

<sup>18</sup> Judge George Timberlake, "Justice System must not worsen harsh realities of life for LGBT youth," *ACEs Too High*, (2015): <https://acestoohigh.com/2015/08/17/justice-system-must-not-worsen-harsh-realities-of-life-for-lgbt-youth/#more-4535>.

<sup>19</sup> John Blosnich and Judith Andersen, "Thursday's Child: The role of adverse childhood experiences in explaining mental health disparities among lesbian, gay, and bisexual, U.S. adults," *Soc Psychiatry Psychiatr Epidemiol.* 50, no. 2 (2015): e3 doi: 10.1007/s00127-014-0955-4.

themselves they are less likely to be able to provide the stable and supportive relationships needed to protect their children from the damages of toxic stress.<sup>20</sup> This reality causes significant adversities to cycle from one generation to the next resulting in predictable patterns of limited educational achievement and poor health.<sup>21</sup>

### **How trauma impacts health outcomes.**

Childhood trauma and toxic stress impacts child and brain development, contributes to risky and health harming behaviors and lays the groundwork for stress related diseases later in life. There is a substantial and ever increasing amount of research and articles available online. A very helpful article includes an American Association of Pediatrics Technical Report from 2012 report entitled “The Lifelong Effects of Early Childhood Adversity and Toxic Stress.”<sup>22</sup> In terms of the intersection between trauma and behavioral health, the Substance Abuse and Mental Health Services Administration. U.S. Dept. of Health and Human Services has published a “Treatment Improvement Protocol” (“TIP”) #57 regarding trauma informed care in behavioral health services.<sup>23</sup> TIP 57 and the literature and resources contained within it has a wealth of information about how trauma impacts the quality of life and health among persons with mental and substance use disorders.

### **Trauma and the Developing Brain.**

At birth and during early childhood a human brain is not fully developed. As a child grows her frontal cortex, which is involved in abstract thought, reasoning, and decision making, will develop and she will form new neural connections.<sup>24</sup> Neural connections are what allow different specialized regions of the brain to communicate with one another. In a developing brain, neural connections that are used often will develop more connections, while lesser used pathways will be pruned and deteriorate.<sup>25</sup> Like water flowing through sand, electrical signals travel along neural connections and carve out pathways in the brain. The more worn the path becomes the more easy it is for signals to travel and patterns of thought and behavior can become almost reflexive. Neurons are designed to change in response to external signals. A child can experience three distinct type of stress responses – positive, tolerable, and toxic.<sup>26</sup> Positive and tolerable stress responses are brief and moderate in magnitude and protective adult relationships can facilitate coping with these types of stress. The most dangerous form of stress response, toxic

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<sup>20</sup> Jack P. Shonkoff and Andrew Garner. “The lifelong effects of early childhood adversity and toxic stress,” *American Academy of Pediatrics* 129, no. 1 (2012): e237, doi:10.1542/peds.2011-2663

<sup>21</sup> Shonkoff and Garner, (2012): e237, and sources cited therein.

<sup>22</sup> Shonkoff and Garner, (2012).

<sup>23</sup> “TIP 57: Trauma-Informed Care in Behavioral Health Services,” *U.S. Department of Health and Human Services*, (2014): <https://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816.pdf>.

<sup>24</sup> Margaret A. Sheridan et al. “The Impact of Social Disparity on Prefrontal Function in Childhood,” *PLoS ONE* 7, no. 4, (2012): <http://doi.org/10.1371/journal.pone.0035744>.

<sup>25</sup> Bruce D. Perry et al. “Childhood Trauma, The Neurobiology of Adaptation and Use-dependent Development of the Brain: How States Become Traits,” *Infant Mental Health J.* 13, no 4 (1995): 271–291.

<sup>26</sup> Shonkoff and Garner, (2012): e235.



stress is a strong, frequent, or prolonged activation of the body's stress response that is not mediated by social support.<sup>27</sup> The experiences of a young child dictate how her brain will develop.<sup>28</sup> When a child experiences only positive or tolerable stress and is able to grow in a healthy, stimulating environment neuroplasticity allows the connections between her sensory regions and her frontal cortex to grow strong. These strong connections facilitate her ability to take in and analyze environmental information quickly and critically throughout her life.

In contrast, when a child experiences toxic stress or has a high number of ACEs this system of neuroplasticity is high-jacked by the chronic stress response. ACEs such as physical abuse, sexual abuse, and physical neglect cause activation in the fear centers of the brain. The amygdala plays a large role in the fight, flight, freeze response that is needed to keep a person safe in a stressful environment.<sup>29</sup> When a child is exposed to trauma for long periods of time or experiences a trigger of her trauma the neural connections between her sensory organs and the amygdala are strengthened and the neural connections to the frontal cortex are neglected. In this way, survival states in the brain that are triggered by stressful experiences become behavior traits.<sup>30</sup> Just as water flows down the path of least resistance electrical signaling will utilize neural connections that have been reinforced by repeat patterns of experience or reasoning. In children, adolescents, and adults who have been exposed to ACEs, neural connections to the amygdala are reinforced and become the path of least resistance for electrical signaling in the brain. As a result, non-threatening stimuli and environments may trigger a fear response in the brain.<sup>31</sup> For example, an adolescent who has a history of physical abuse may react violently to a being bumped accidentally by another student in the hall at school. Instead of sending the sensory signals from this encounter to the frontal cortex where they can be processed and interpreted as non-threatening the signals follow the many neural paths that lead to the amygdala. The amygdala interprets the bump as an attack and releases hormones that sends the adolescent into fight or flight mode.<sup>32</sup> Constantly interpreting an environment as threatening can exhaust an individual's body and spirit. Toxic stress can interfere with the ability to learn, to cope with negative or disruptive emotions, and contribute to emotional and cognitive impairment.<sup>33, 34</sup>

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<sup>27</sup> Shonkoff and Garner, (2012): e236.

<sup>28</sup> Sheridan et al. (2012).

<sup>29</sup> Margaret A. Sheridan and Katie A. McLaughlin. "Dimensions of Early Experience and Neural Development: Deprivation and Threat," *Trends in Cognitive Sciences* 18, no. 11 (2014): 580–585, doi:10.1016/j.tics.2014.09.001.

<sup>30</sup> Sheridan and McLaughlin, (2014).

<sup>31</sup> "Early Childhood Adversity, Toxic stress, and the Role of the Pediatrician: Translating Developmental Science into Lifelong Health," *American Academy of Pediatrics*, (2012): 224-231, <http://pediatrics.aappublications.org/content/129/1/e224>.

<sup>32</sup> "Early Childhood Adversity." (2014).

<sup>33</sup> Shonkoff and Garner, (2012): e236.

<sup>34</sup> Sheridan and McLaughlin. (2014): e4.

## ACEs, Toxic Stress and Educational Outcomes.

Changes to the brain can impair academic efforts as they affect memory systems, the ability to think and to organize multiple priorities (executive function).<sup>35</sup> Students with three or more ACEs are significantly more likely to be unable to perform at grade level, be labeled as special education, be suspended, be expelled or drop out of school.<sup>36</sup> Research strongly links suspension and other school discipline to failure to graduate. As trauma exposure increases the likelihood of learning and behavioral issues, it also increases the likelihood of criminal justice involvement.<sup>37</sup>

Over time, and often during adolescence, the child adopts coping mechanisms, such as substance use which can then contribute to disease, disability and social problems as well as premature mortality.<sup>38</sup> As a child moves through adolescence and into adulthood her ability to form new neural connections deteriorates and the structure of her brain becomes increasingly less plastic.<sup>39</sup> Without comprehensive, appropriate treatment, structural changes in the brain can persist decades after a trauma.

## The Connection between Trauma, Substance Use Disorders and Behavioral Health

**Trauma and Substance Abuse and Dependence.** There is clearly a correlation between trauma and substance use as well as the presence of PTSD and substance use disorders.<sup>40</sup> At the behavioral level, there is “extensive evidence of a strong link between early adversity and a wide range of health-threatening behaviors.”<sup>41</sup> The association between ACE and unhealthy adult lifestyles is well documented and adolescents with a history of ACEs are more likely to initiate alcohol at a younger age and are more likely to use it “as a means of coping with stress than for social reasons.”<sup>42, 43</sup> The adoption of unhealthy lifestyles as a means of coping may also explain

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<sup>35</sup> “Education Brief: ACEs for educators and Stakeholders,” The Illinois ACEs Response Collaborative, (2016): e1.

<sup>36</sup> Robert Balfanz, Vaughan Byrnes, and Joanna Fox, “Sent home and put off-track: The antecedents, disproportionalities, and consequences of being suspended in the ninth grade,” *Journal of Applied Research on Children: Informing Policy for Children at Risk* 5, no. 2 (2014): <http://digitalcommons.library.tmc.edu/childrenatrisk/vol5/iss2/13>

<sup>37</sup> Nancy Wolff and Jing Shi, “Childhood and Adult Trauma Experiences of Incarcerated Persons and Their Relationship to Adult Behavioral Health Problems and Treatment,” *Int J Environ Res Public Health* 9, (2012): 1908–1926, doi: 10.3390/ijerph9051908).

<sup>38</sup> <https://captus.samhsa.gov/prevention-practice/targeted-prevention/adverse-childhood-experiences/1>.

<sup>39</sup> Udo Dannlowski et al. “Limbic Scars: Long-Term Consequences of Childhood Maltreatment Revealed by Functional and Structural Magnetic Resonance Imaging,” *Priority Communication*, (2012): <https://doi.org/10.1016/j.biopsych.2011.10.021>.

<sup>40</sup> “TIP 57,” (2014): e86.

<sup>41</sup> Shonkoff and Garner, (2012): e237.

<sup>42</sup> Shonkoff and Garner, (2012): e237.

<sup>43</sup> Several studies have found that substance use develops following trauma exposure (25%-76%) or the onset of PTSD (14%-59%) in a high proportion of teens with substance use disorders. And research suggests traumatic stress or PTSD may make it more difficult for adolescents to stop using, as exposure to reminders of the traumatic event have been shown to increase drug cravings in people with co-occurring trauma and substance abuse. See, “Understanding the Links Between Adolescent Trauma and Substance Abuse, a Toolkit for Providers 2<sup>nd</sup> Edition,”

why higher ACE exposures are associated with tobacco use, illicit drug abuse, obesity and promiscuity.<sup>44</sup> Alcohol and drug use can be, for some, an effort to manage traumatic stress and specific PTSD symptoms.<sup>45</sup>

In addition to the “self-medication” hypothesis that persons impacted by trauma use substances to manage related symptoms, the link between trauma and substance use is complex and runs two ways: trauma exposure increases the likelihood of substance and substance abuse increases the likelihood of experiencing trauma.<sup>46</sup> As the pathways run both ways, youth with trauma exposure and SUD experience difficulties with emotional and behavioral regulation and require a treatment approach that addresses both and is flexible enough to accommodate myriad ways trauma and substance abuse may be related.<sup>47</sup> Research indicates that efforts to prevent substance abuse may not be effective unless ACEs are addressed as a contributing factor to an individual’s substance use.<sup>48, 49, 50</sup> Thus, substance abuse, a common but often unhealthy coping mechanism, can contribute over time to additional trauma, disease, disability and social problems.<sup>51</sup> Adolescents and adults “who manifest higher rates of risk taking behaviors are also more likely to have trouble maintaining supportive social networks and are at higher rate of school failure, gang membership, unemployment, poverty, homelessness, violent crime, incarceration and becoming single parents.”<sup>52</sup>

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*The Adolescent Trauma and Substance Abuse Committee of the National Child Traumatic Stress Network*, (2008): 6-76, and sources cited therein (Available online at [www.nctsn.org](http://www.nctsn.org)).

<sup>44</sup> Shonkoff and Garner, (2012): e237, and sources cited therein. See also, Felitti VJ. Adverse Childhood Experiences and Adult Health. *Acad. Pediatr.* 2009.9(3):131-132 (toxic stress in childhood is associated with the adoption of unhealthy lifestyles as a coping mechanism).

<sup>45</sup> “TIP 57,” (2014): e87.

<sup>46</sup> “TIP 57,” (2014): e87, citing Chilcoat and Breslau’s seminal work (1998).

<sup>47</sup> “Understanding the Links Between Adolescent Trauma and Substance Abuse, a Toolkit for Providers 2<sup>nd</sup> Edition,” *The Adolescent Trauma and Substance Abuse Committee of the National Child Traumatic Stress Network*, (2008): e7, [https://www.nctsn.org/sites/default/files/resources//understanding\\_the\\_links\\_between\\_adolescent\\_trauma\\_and\\_substance\\_abuse.pdf](https://www.nctsn.org/sites/default/files/resources//understanding_the_links_between_adolescent_trauma_and_substance_abuse.pdf)

<sup>48</sup> “Understanding the Links,” (2008): e7, e27.

<sup>49</sup> Underage drinking prevention programs may not work as intended unless they help youth recognize and cope with stressors of abuse, household dysfunction, and other adverse experiences. Learn more from a [2008 study on how ACEs can predict earlier age of drinking onset](#) (link is external) and <https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences>

<sup>50</sup> “TIP 57,” (2014): e87.

<sup>51</sup> Numerous epidemiological studies have found that for many adolescents, (45-66%) substance use disorders preceded the onset of trauma exposure. There is a direct link between alcohol use and risky behaviors—hitchhiking, walking in unsafe neighborhoods, and driving. Adolescents with SUD are significantly more likely than non-using peers to experience trauma that results from risky behaviors, including harm to themselves or witnessing harm to others. Moreover, youth who are abusing substances may be less able to cope with a traumatic event—as a result of the functional impairments associated with problematic use. Research suggests that the extensive psychosocial impairments found in adolescents with SUD occurred in part because they lacked the skills necessary to cope with trauma exposure. “Understanding the Links,” (2008): e6-e7, and sources cited therein.

<sup>52</sup> Shonkoff and Garner, (2012): e237.

**Trauma and other Mental Health Impairments.** There is a range of research and literature available regarding how trauma exposure and related disorders co-occur with and negatively affect the course of serious mental illness—often causing more severe symptoms and a worse course of illness. Early exposure to “severe and chronic trauma is linked to more complex symptoms including impulse control deficits, greater difficulty in emotional regulation and establishing stable relationships, and disruptions in consciousness, memory, identity and perception of the environment.”<sup>53</sup> Persons with PTSD often have at least one additional diagnosis of a mental disorder, and the presence of other disorders typically worsens and prolongs the course of PTSD and complicates clinical assessment, diagnosis and treatment.<sup>54</sup> Major Depressive Disorder is the most common co-occurring disorder in people who have experienced trauma and are diagnose with PTSD. A “well established causal relationship exists between stressful events and depression” and co-occurrence is linked with greater impairment and more severe symptoms of both disorders, and the person is less likely to experience remission of symptoms within 6 months.<sup>55</sup> In addition:

Generalized anxiety, obsessive-compulsive, and other anxiety disorders are also associated with PTSD. PTSD may exacerbate anxiety disorder symptoms, but it is also likely that preexisting anxiety symptoms/disorders increase vulnerability to PTSD. Preexisting anxiety primes survivors for greater hyperarousal and distress. Other disorders, such as personality and somatization disorders, are also associated with trauma, but the history of trauma is often overlooked as a significant factor or necessary target in treatment.

Id. at 86.

Additional connections that have been found between trauma exposure and trauma-related disorders in severe mental illness include:

- Childhood Sexual abuse (SA) and childhood emotional abuse (EA) are associated with 8-9 year earlier onset of illness in major depressive disorder.
- Childhood physical abuse (PA) and childhood SA were strongly associated with PTSD in psychotic subtypes of major depressive disorder.
- Childhood trauma exposure had a negative effect on the course of illness in schizophrenia spectrum disorder.
- Severity of trauma exposure was associated with positive symptoms of schizophrenia.
- SMI patients with a history of both PA and SA attempted suicide five times more frequently.

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<sup>53</sup> “TIP 57,” (2014): e87, citing Dom, De, Hulstijn, & Sabbe, 2007; Walkdrop, Back, Verduin, & Brady, 2007).

<sup>54</sup> “TIP 57,” (2014): e86.

<sup>55</sup> “TIP 57,” (2014): e86.

- Co-morbid lifetime PTSD predicted a worse clinical outcome for bipolar disorder: a 6-year earlier start of the symptoms, more severe symptoms, more suicide attempts and ultra-rapid cycling of mood swings.
- PTSD was associated with more severe symptoms and more suicide attempts for major depressive disorder. It was also four times more present for the psychotic subtypes of major depressive disorder than for the non-psychotic subtypes.
- PTSD related significantly to Axis I co-morbidity and severe emotional dysregulation in Borderline Personality Disorder (BPD).
- Complex PTSD related significantly to a chronic course of illness, severe clinical conditions, and more self-destructive behavior and suicide attempts in Borderline Personality Disorder.<sup>56</sup>

Along with an increase in the severity of psychiatric symptoms for persons with co-occurring trauma exposure/disorders and other mental impairments (such as hallucinations, delusions, depression, suicidality, anxiety, hostility and dissociation), there is also an increase use of acute-care service.<sup>57</sup> Unfortunately, the use of services doesn't correlate with improved health outcomes; Americans with serious mental illness die 15 to 30 years earlier than those without, most often due to chronic disease.<sup>58</sup>

### **Trauma Exposure and chronic health conditions in adults later in life.**

Even in the absence of health-threatening behaviors, ACEs and toxic stress in childhood has also been “shown to cause physiologic disruptions that persist into adulthood and lead to frank disease.”<sup>59</sup> PTSD, violence exposure, and high numbers of Adverse Childhood experiences (ACEs) are associated with negative health outcomes later in life. The more types and longer duration of victimization, the more severe the impact on health outcomes, symptoms, and intractability.<sup>60, 61</sup> Adults who have been exposed to trauma have an increase in the number and

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<sup>56</sup> Mauritz et al. (2013): e10, and sources cited therein.

<sup>57</sup> Rosenberg et al. “Trauma Exposure and PTSD in people with severe mental illness,” *PTSD Research Quarterly* 13, no. 3 (2002): e3, and source cited therein. See also, Rosenberg et al. “Correlates of Adverse Childhood Events among Adults with Schizophrenia Spectrum Disorders,” *Psychiatric Services* 58, no. 2 (2007): e246. There is emerging evidence that childhood sexual abuse and physical abuse are related to more severe symptoms among people with schizophrenia and other severe mental illnesses.

<sup>58</sup> Khullar, Dhruv, “The Largest Health Disparity We Don’t Talk About”, *New York Times* (5/30/18).

<sup>59</sup> Shonkoff and Garner, (2012): e238, and sources cited therein.

<sup>60</sup> Alexander C. McFarlane, “The long-term costs of traumatic stress: intertwined physical and psychological consequences,” *World Psychiatry*, (2010): e5.

<sup>61</sup> Eve M. Sledjeski, Brittany Speisman, and Lisa Dierker, “Does number of lifetime traumas explain the relationship between PTSD and chronic medical conditions? Answers from the National Comorbidity Survey-Replications (NCS-R),” *Journal of Behavioral Medicine* 31, no. 4 (2008): doi:10.1007/s10865-008-9158-3.

severity of health related outcomes compared to non-trauma exposed adults.<sup>62</sup> Adults who experience at least one ACE are more likely to report worse health, functional limitations, and be diagnosed with diabetes or heart issues than individuals with no ACE exposure.<sup>63</sup>

Research regarding the health effects related to an expanded conception of adverse experiences – such as racial discrimination (in childhood and adult)—further shows that adverse experiences such as prejudice is “internalized over a lifetime and linked to a variety of poor health markers and outcomes: more inflammation and worse sleep; smaller babies and higher infant death rates; a greater risk of cancer, depression and substance use.”<sup>64</sup>

## Conclusion

The far reaching negative health effects of ACEs and other trauma exposure can interrupt learning and education, increase the risk of significant co-morbidities and devastate adult health. The research about the far reaching effect of trauma on adult health is compelling and can and should be integrated into disability law practice—and not only when a client is diagnosed with PTSD or other stressor related disorder.

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<sup>62</sup> Isabelle Chaudieu et al. “Late-life health consequences of exposure to trauma in a general elderly population: The mediating role of re-experiencing posttraumatic symptoms,” *The Journal of Clinical Psychiatry* 72, 7 (2011): doi: 10.4088/JCP.10m06230.

<sup>63</sup> Shannon M. Monnat and Raeven F. Chandler. “Long term physical health consequences of Adverse Childhood Experiences,” *The Sociological Quarterly* 56, no. 4 (2015): <http://doi.org/10.1111/tsq.12107>.

<sup>64</sup> See, Khullar, Dhruv, How Prejudice can Harm Your Health, NY Times, June 8, 2017, referencing Racism and Health I: Pathways and Scientific Evidence *Am Behav Sci.* 2013 Aug 1; 57(8): 10.1177/0002764213487340. Published online 2013 May 8. doi: [10.1177/0002764213487340](https://doi.org/10.1177/0002764213487340).

## **II. How to Identify Trauma and Engage Clients in a Trauma Informed Way**

Research makes clear that trauma and/or exposure to toxic stress is very likely when an adult reports or their story contains certain indicators.

### **Common Trauma Indicators**

- failed or very limited educational achievement
- low or no vocational accomplishment
- involvement in the justice system
- unstable personal and familial relationships
- depression and anxiety
- chronic illnesses including chronic pain complaints and somatic symptoms
- Substance misuse, abuse or dependence—especially if started in childhood/adolescence
- Chronic homelessness

In addition to these “indicators”, because trauma disorders are often under and misdiagnosed and because many people have “sub-clinical” PTSD related symptoms that contribute to the severity and complexity of other conditions, you can remain “trauma aware” by considering the following symptoms as evidenced by your observation of your client, your interaction with your client, and their narrated story:

### **Common Trauma Symptoms**

- **Hypervigilance**
- **Low Self-Esteem**
- **Avoidance**
- **Isolation**
- **Mistrust**
- **Somatic**

### **Trauma Informed Engagement**

Being trauma informed in a Social Security disability practice increases your likelihood of success because it strengthens the relationships you maintain with clients, holds the greatest potential for increasing treatment compliance and it helps you to cultivate essential evidence that goes to the ultimate question in a disability claim: how the nature, intensity and severity of your client’s physical and mental health condition/s negatively impacts their ability to function/work.

To effectively engage a client who is impacted by trauma, there are universally recognized key elements or principles: 1) emotional safety; 2) transparency/trustworthiness; 3) choice and collaboration; and 4) empowerment.

1) **Provide Emotional safety**—"do no harm". Be non-judgmental, express your concern and support.

- Ask your clients about their pasts, tell them why you are asking. "I tend to ask a lot of questions. I find that the more I know about you and your experiences, the more effective I can be in helping you."
- You told me you stopped going to school in the 8<sup>th</sup> grade, can you tell me more about what was going on in your life then?
- Can you share with me about what your childhood was like (safe? happy? stable? chaotic? stressful?)?
- Many people who have, as you have shared, ( ....left school early, used opiates long term....been in and out of the penitentiary...), have experienced a lot of trauma in their lifetimes...what has your experience been?
- Normalize "negative" disclosures (early school drop-out, substance use, gang involvement) as adaptive responses to trauma and toxic stress.

Focus not on "what is wrong with you" but rather, "what has happened to you."

When trauma is identified, acknowledge its relevance. Explain that research tells us that trauma can often have a big effect over a lifetime. Always seek permission and pay attention to body language to determine if an initial and when called for, deeper conversation on the topic is ok. Have conversations with your client around:

- Do they feel/think that their trauma history relates to their physical impairments? How/why?
- Do they feel/think their trauma history relates to their mental health conditions? How/why?
- If they use substances, as them which came first, trauma/adversity or substance use?
- Do they feel/think their trauma exposure is related to their use of substances? How/why?
- How does their substance use make them feel? (before, during and after)
- Have they talked to anyone—personal or professional about their experience with trauma?
- What are their thoughts/feelings about their physical/mental/behavioral health care and treatment? Has trauma ever been addressed? What if anything, would they like to change?



**2) Transparency/Trustworthiness:** maximize trustworthiness, make tasks clear, maintain appropriate boundaries.

- What will you do and when will you do it? Be explicit about what to expect (how fast will you return phone calls? who will actually work on case?).
- Discuss the legal implications of ongoing substance use without judging the behavior—will it affect your representation? Might it affect the outcome of the case?
- How long will the claim likely take? What will you do, what do you expect of the client? (will your representation be contingent upon any “compliance” issues?)
- Establish boundaries and be consistent.

**3) Choice and Collaboration:** Bring your knowledge, tap into clients’ expertise and experience. Prioritize client choice and control over behavioral health engagement and whether and to what extent trauma is addressed in the development of the claim. Will the client pursue/continue to pursue medication? therapy? trauma informed therapy? methadone? Explain and give information about the legal consequences of choices.

- How do you feel about the medication you’ve been prescribed?
- What medication/therapy/care has worked best?
- What are your thoughts about changing your medical care provider to a clinic with a more holistic approach to care?
- I’m concerned about how the judge will react to the positive cocaine screens, what are your thoughts?
- Share what you know about the research around trauma—e.g. that substance use is an adaptive response by persons who have been exposed to trauma.
- Share with the clients your perception of the evidence and overall claim—brainstorm with them weaknesses/ways to reconcile
- Agree on what the client is and is not comfortable talking about, agree on language used
- Collaborate and agree on how to get relevant trauma related information into the record.

**4) Empowerment:** identify what clients are able to do for themselves, acknowledge adaptive skills and “heavy lifting” around recovery (vs. disability determination focus on deficits).

- **Utilize Motivational Interviewing (MI)** –especially when “change” is important to successful outcome of the claim (treatment compliance, reduction of substance use). MI

is an evidence based approach to helping people overcome ambivalence. “Helping people talk themselves into changing”.<sup>65</sup>

- A counseling approach in part developed by clinical psychologists based upon their experience treating problem drinkers. Thoughtful, collaborative, empathic. Adaptable to working with persons with co-occurring disorders—evidence shows it improves treatment adherence for persons with mental health and substance use disorder as well as chronic health conditions.
- **OARS:** (four basic interactive skills) *People don’t hear until they have been heard:*
  - **Open Ended Questions**-how are you? What’s been going on? How can I help you? How would you like things to be different?
  - **Affirmations**-acknowledge positive behavior, support strengths
  - **Reflective Listening**—mirror back, develop discrepancies.
  - **Summary**-pull together what’s been shared.
- **Evocative**—“I learn what I believe as I hear myself speak.” Helps clients to build motivation and skills to make the best choices for themselves. MI is a **way of being, not skill set—very consistent with being trauma informed.**

Again, in any conversation or interaction with your client during which time ACE’s or trauma is being discussed, pay attention to your client’s body language. Ask for permission before proceeding. If a client appears uncomfortable with the content of a conversation I will often ask if they have shared their experience with someone else—see if there is a record I can obtain that would contain the information rather than hearing it from the client first hand. Also, before exiting an emotionally charged conversation, help the client get grounded in the present. Acknowledge that you have covered some difficulty topics. Explore how they are feeling. Ask them about their plans, how they are feeling and what sorts of supports they find useful to cope. Express your concern and support.

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<sup>65</sup> There are vast resources online regarding motivational interviewing—trainings, books and other materials. Check out SAMSHA/Clinical Practice/Motivational Interviewing for a start.

### **III. Utilize trauma awareness, science of ACES and trauma research in your application of the sequential evaluation process.**

The impact of ACEs and other trauma can be evidenced at every stage of the sequential evaluation process in a Social Security disability claim. First, in terms of substantial, gainful activity, a trauma impacted claimant is more likely to have little or no current work activity. Rather, it is likely that childhood trauma derailed their education, contributed to learning problems, led to health harming behaviors and might have resulted in criminal justice involvement. Attempts at work are often short lived due to severity of symptoms, limited coping skills and the absence of stable social supports. Any medically determinable impairment that exists in the context of ACEs and toxic stress is likely to be severe. Physical and somatic symptoms such as pain, fatigue or shortness of breath result in exertional limitations. Common trauma related symptoms such as depression, anxiety, mood instability, re-experiencing and avoidance (often indicated by substance use and treatment noncompliance) interfere with the ability of persons to function day to day, and may have contributed to school failure, inability to sustain work and often, led to homelessness. Because of significant symptom overlap between trauma related symptoms and other serious mental illness and because serious mental illness in the context of ACEs and other trauma can have more severe symptoms that are hard to treat, a claimant will likely meet or equal a listing level impairment—including but not limited to Listing 12.15. In terms of the ‘B’ criteria, cognitive impairment related to trauma can impair the ability to understand, remember and apply information. Regarding the ability to interact with others, persons who are impacted by trauma often have issues with trust and are isolated; the adoption of health harming behaviors to cope also leads to social problems. In addition, the ability to concentrate, persist and maintain pace can be markedly impaired due to hypervigilance, involuntary re-experiencing, and mood instability and sleep disturbance. Finally, because ACEs and trauma exposure can contribute to the severity of symptoms and complexity of conditions, with the likelihood of significant physical and mental health comorbidities, it is likely that claimants will be markedly if not extremely impaired in their ability to adapt or manage oneself (regulate emotions, control behavior, and maintain well-being) in a work setting.

Similarly, ACEs and exposure to trauma will likely reduce a persons’ residual functional capacity to a point that is work preclusive—particularly with regard to their ability to complete a normal work day and work week without the interruption of psychological symptoms, to adapt to the structure of and changes within a work setting and to manage and adapt to work stress. Finally, if a claimant is determined disabled and there is evidence of current alcohol or illicit substance abuse or dependence (“DAA”), the lifelong impact of trauma can be essential to proving that DAA is not a contributing factor material to the determination of disability.

**Evidence Development.** Because adults who are impacted by ACEs and toxic stress generally have a life trajectory consistent with ACEs and toxic stress, the potential evidence to collect can cover decades. Because of significant comorbidities including substance use, it is critical to fully develop the record.

- Longitudinal Development—if it started in childhood, prove it to childhood
- Detailed and Accurate Analysis of Medical Evidence-SOAP
- Comprehensive Evaluations/Use of Mental Health Expert Witnesses
- “Other” Non-Medical Sources-Importance of Witnesses
- Rigorous Application of the Law/Advocacy

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*Sometimes it goes to severe impairment, sometimes it's a Listing, sometimes it's an RFC factor, sometimes it's a unifying theme that makes a case compelling.*

**Longitudinal Development**—the common policy/practice of requesting records one year prior to alleged onset date is not effective in documenting a SMI ever, and certainly not in complex case involving co-occurring substance use and trauma. You want to develop the evidence to the earliest point in time when client began manifesting any symptom that is related to trauma, mental health symptoms or substance use—school records, closed DCFS records, early

behavioral health records, substance abuse treatment records, records from correctional facilities. These records document the story—the common trajectory of a person’s life when impacted by trauma.

- Lends weight to arguments around severity and functional impairment
- Explains trajectory of life—impacted by symptoms for which may or may not have been diagnosed and treated
- Credibility—establishes credibility around complaints around symptom severity, intractability, medication inefficacy/noncompliance.

**Accurate, in depth assessments and evaluations:** When the available evidence does not accurately and persuasively document your client’s diagnoses, functional limitations, and/or complex histories, consider additional evaluations and testing. Cultivate relationships with trauma informed providers and pay for evaluations when necessary. More and more behavioral health programs are screening for trauma, recommending behavioral health therapies to address trauma, and considering trauma in treatment planning. Some of available tests/assessments include:

- Screen for Posttraumatic Stress Symptoms (SPTSS)-A very brief self-report instrument for PTSD symptoms that can be used with persons who report single, multiple or no traumatic events. Its brevity and low required reading level make it an efficient screening tool for symptoms related to PTSD.
- Posttraumatic Stress Disorder Checklist—Civilian Version (PCL-C)-The PCL is a 17-item self-report measure reflecting DSM-IV symptoms of PTSD diagnosis by endorsing symptomatic responses to at least 1 “B” item (e.g. “Repeated, disturbing dreams of a stressful experience from the past”), at least 3 “C” items (e.g. “Avoiding

activities or situations because they reminded you of a stressful experience from the past”. “Loss of interest in activities that you used to enjoy”, “Feeling distant or cut off from other people”) and at least 2 “D” items (e.g. “Trouble falling or staying asleep”, “Being ‘super alert’ or ‘watchful or on guard’”).

- Beck Depression Inventory (BDI)-The BDI is a face valid depression self-report measure. Examples of statements on the BDI include: I feel I am being punished. I blame myself for everything bad that happens. I feel irritated all the time now.”
- Beck Anxiety Inventory (BAI)-The BAI is a valid self-report measure of anxiety. Examples of common symptoms of anxiety rated include: unable to relax, fear of worst happening, nervous, hand trembling, shaky/unsteady, and fear of losing control.
- GAIN I-A comprehensive bio-psychosocial assessment designed to support clinical diagnosis, placement and treatment planning in behavioral health/recovery support settings. Includes assessment of lifetime victimization.
- Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)-Assesses the 20 DSM-5 PTSD symptoms and questions target the onset and duration of symptoms, subjective distress, impact of symptoms on social and occupational functioning, improvement in symptoms since a previous CAPS administration, overall response validity, overall PTSD severity, and specifications for the dissociative subtype (depersonalization and derealization).
- Lifetime Events Checklist-LEC-A measure of exposure to potentially traumatic events, developed by the National Center for Post Traumatic Stress Disorder concurrently with the Clinician Administered PTSD Scale (CAPS) to facilitate the diagnosis of PTSD.

**Evidence Reconciliation:** This can be especially important if your client has a co-occurring substance use disorder/s. Reconcile the evidence with your client’s story and across the record. Do the records match you client’s description of report of symptoms? Treatment? Substance use history/specifiers? Are the records consistent? Contradictory? Does your client disclose trauma history or substance use consistently (if not, clarify this with your client and develop a strategy to address it). Is s/he believed by providers?

- Ask treating providers to clarify/amend diagnoses if facts support change. With client’s consent, share longitudinal records as appropriate.
- Review evidence with client—keeps you neutral, motivates change. (in motivational interviewing parlance, helps to “develop discrepancies”—the gap between a client’s behavior and their personal (legal) goals).

**Pre-hearing Statements-An essential component to effective advocacy.** Most effective with a chronological summary of medical evidence from inpatient and outpatient settings that includes the following information:

- Subjective report of sxs/problem/complaint
- Objective—evaluator’s perspective, MSE
- Assessment (diagnosis)
- Plan of Treatment (did client follow up?)

You have to capture the subjective and objective because diagnosis and treatment of mental impairments includes both. Trace the treatment plans and next medical encounter-did the client follow up? If not, why not? Was trauma ever asked about? Was it consistently disclosed? If not, why not? I find that trauma disclosure can be very context specific—depending upon the gender, age and race of the patient/provider, the treatment setting (psychiatric inpatient vs. prison vs. recovery program) and other factors. Sharing what you learn from the record about when and under what circumstances your client disclosed trauma can add strength and cohesion to your factual narrative and argument.

Also, look specifically at research around trauma and the specific physical or mental impairment your client reports or is diagnosed with, and, if your client has a trauma history, consider how trauma may have impacted your client’s course of treatment (including avoidance of it), their reaction to treatment, and episodes of relapse and recovery. Consider whether the treatment was “appropriate” and/or evidenced based, did recovery support program address trauma history and symptoms? If not, it may have contributed to treatment “non-compliance” or inefficacy.

A well written Statement/Argument can often reduce the amount of questioning a client must endure at a hearing-and sometimes avoid the need to appear at a hearing altogether. A trauma informed approach aims to accommodate clients who cannot tolerate additional or intolerable stress. The next section looks more specifically at the sequential evaluation process and provides some sample language from Pre-Hearing Statements and suggestions on how to integrate trauma exposure and research in to your legal analysis.

## **Integrating ACEs and Toxic Stress to your Legal Analysis—the Sequential Process**

### **The Sequential Evaluation Process**

- Step 1 Substantial Gainful Activity-work “without regard to legality”
- Step 2 Severity-significantly limits your physical or mental ability to do basic work activities
- Step 3 Listings of Mental Impairments
- Step 4 RFC, MRFC (limitations from complex, chronic physical and mental health conditions)
- Step 5 Vocational factors (education and work experience), adaptability, susceptibility to stress
- Step 6--DAA Determination (when necessary)

When a claimant has the comorbidities of chronic physical health conditions, serious mental illness and/or substance use disorder in the context of significant ACEs and/or other trauma exposure, there are many ways in the sequential evaluation process to present how the comorbid conditions cause severe symptoms and marked functional impairments. Integrating and referencing research regarding trauma can help strengthen your client’s claim and inform adjudicators and judges about the significance of trauma on adult physical and behavioral health.

**Substantial Gainful Activity: Step 1**—As previously described, ACEs and toxic stress interfere with brain development and can result in learning challenges, disrupt educational attainment, and result in health harmful behaviors as a means to cope. All of these are likely to result in limited work experience and earnings records that establish that your client has never sustained work at the SGA level. If your client’s work history is consistent with and/or explained by ACEs and toxic stress, you can mention it at this step. In addition, because of the correlation between trauma exposure and substance use, many clients will be engaged in some sort of “gainful” activity to support their use, often referenced in the medical exhibits related to the cost of their daily use of illicit substances. Always get in front of this before the adjudicator or judge—it needs to be explained, mitigated or contextualized so as not to amount to SGA or unduly prejudice your claim.

**Severe Impairment: Step 2**—Severe Impairment, for persons who are impacted by significant trauma, the existence of one or more SMIs, co-occurring substance use and other physical impairments are likely to result in severe impairment—having caused more than minimal interference with a person’s ability to function/work and to have lasted 12 months or more. Research shows that persons with high ACE scores often have early behavioral health symptoms, risky behaviors, limited educational achievement, low vocational accomplishment, and high rates of disability. Client’s with significant co-morbidities are likely to have fractured social relationships or be socially isolated, history of housing instability or homelessness, multiple failed or short lived work attempts and dependence upon community support and human services programs to remain stable in the community. Sample language (including footnote) follows.

**Sample 1:** Mr. Doe has the following severe impairments: Major Depressive Disorder, Post-Traumatic Stress Disorder (See, Ex. 6F-2, Ex. 10F-4, Ex. 15F-5, Ex. 16F-5), Alcohol Abuse (Ex. 12F at 4-5), Cocaine Abuse (Ex. 12F at 4-5).

Mr. Doe’s mental impairments and co-occurring substance use disorders are grounded in severe childhood trauma and a chaotic upbringing that included physical abuse, extreme punishment, lack of basic needs, care and love. See, Ex. 12F-54; Ex. 13F-17; Ex. 3F-4, 23; Ex. 10F-1; Ex. 15F-8, 18, 25. As a predictable result of these adverse childhood experiences, Mr. Doe began using substances at a very young age (age 11-13) and hanging with the “wrong” crowd. (footnote 1). Ex. 1F-5; Ex. 3F-23. Low educational achievement (10<sup>th</sup> grade), unstable and uneven work history, “a long history of sad feelings” (Ex. 3F-4) and episodic but overall long term homelessness has been the result. Thus, his conditions are severe.

<sup>1</sup> Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical diseases in adulthood. SAMSHA “Concept of Trauma and Guidance for a Trauma-Informed Approach, July 2014 (“SAMSHA Trauma and TIC”) at p. 2 (citing Felitti, G., Anda, R., Nordenberg, D., et al., (1998). Relationship of child abuse and household dysfunction to many of the leading cause of death in adults: The Adverse Childhood Experiences Study. American Journal of Preventative Medicine. 14, 234-258; Dube, S.R., Felitti, V.J., Dong, M., Chapman, D.P., Giles, W.H., and Anda, R.F (2003). Childhood abuse, neglect and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experiences Study. Pediatrics, 111 (3), 564-572. Traumatic effects, which may range from hypervigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down physically, mentally and emotionally. SAMSHA at 8.

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**Sample 2:** Ms. Blue has the following severe impairments: Bipolar Disorder, Post Traumatic Stress Disorder, Borderline Personality Disorder, Cocaine Dependence, Chronic back and hip pain due to traumatic injury, and Asthma. She has also been diagnosed by DDS Consulting Psychiatrist and Psychiatry within Illinois Department of Corrections with Rule/Out Learning Disability. Ex. 15F-4; Ex. 6F at 12-14; Ex. 7F-58.

Ms. Blue’s mental impairments are severe because they have resulted in early interruption to her education, risky behavior beginning in childhood including running away from home and early and chronic use of substances to cope (primarily cocaine), approximately 24 years of homelessness in adulthood, fractured relationships (she has seven children but has lost custody of all) and the inability to sustain work.

### **Listings of Impairments—Step 3 – 12.15 and Beyond**

Because of the significant overlap of symptoms between trauma related disorders and other SMI, and because of the high rate of co-morbidity between trauma, SMIs and substance use disorders, cases involving these conditions can be argued under multiple listings. Though the new Listing for Trauma and Stressor related disorders (12.15) is a welcome addition to the Listings of Mental Impairments, Listings that cover other serious mental illnesses—including affective and anxiety



related disorders and somatic symptom disorders—should always be considered when developing a legal argument on behalf of a client who is impacted by trauma. Proceed under the Listing that comes closest to describing the symptoms that are most problematic (and well documented) for your client. Frequently, trauma first manifests in physical/somatic symptoms that may seem inconsistent or incongruous with the medical evidence or, as the evidence shows, contributes to chronic physical ailments. Without a trauma lens applied, judges and adjudicators may attach less weight to symptoms based upon the objective medical evidence and conclude a person can perform work related activities. Evidence of trauma and somatic symptoms can help close the evidence gap—regarding the nature, severity and persistence of impairments and even substantiate a 12.07 Somatic Symptoms Listing (ask for a consultative psychiatric evaluation if necessary!).

In addition, the New Listings of Mental impairments expands the list of “acceptable medical sources” to include APRNs, NPs, Physician Assistants and others who may treat clients who have been impacted by trauma. The Listings also indicate SSA will explicitly consider psychosocial supports provided by crisis response teams, social workers, or community mental health workers. These sources are much more likely to document trauma histories, ongoing trauma exposure, ongoing psychological symptoms and functional limitations. Records from these sources can be very helpful to establish the severity and functional impact—the ‘B.’ and ‘C.’ criteria of any listed mental impairment and areas of impairment in an MRFC assessment. Persons with serious mental illness/s and trauma histories are very likely to have marked limitation in the ‘B.’ areas including the new ‘B. 2.’ criteria (Interact with others) and ‘B. 4’ criteria (Adapt and Manage Oneself in a work setting) (as well as understanding, remembering an applying information and concentration, persistence and pace).

The description of each Listing has been moved to the introductory section in the new Mental Impairment Listings (issued 9/26/16, effective 1/17/17) and reflect terminology in the DSM-V. Be sure to consider the description of the individual Listing and not just the specific ‘A.’ criteria when developing your legal theory. It is the most broad and inclusive language that best describes the range and complexity of symptom presentation and thus is helpful in claims where several different serious mental illnesses or range of symptoms is present.

For example, the description of *Trauma- and stressor-related disorders (12.15)* provides:

- a. These disorders are characterized by experiencing or witnessing a traumatic or stressful event, or learning of a traumatic event occurring to a close family member or close friend, and the psychological aftermath of clinically significant effects on functioning. Symptoms and signs may include, but are not limited to, distressing memories, dreams, and flashbacks related to the trauma or stressor; avoidant behavior; diminished interest or participation in significant activities; persistent negative emotional states (for example, fear, anger) or persistent inability to experience positive emotions (for example, satisfaction, affection);

anxiety; irritability; aggression; exaggerated startle response; difficulty concentrating; and sleep disturbance.

- b. Examples of disorders that we evaluate in this category include posttraumatic stress disorder and other specified trauma- and stressor-related disorders (such as adjustment-like disorders with prolonged duration without prolonged duration of stressor).
- c. This category does not include the mental disorders that we evaluate under anxiety and obsessive-compulsive disorders (12.06), and cognitive impairments that result from neurological disorders, such as a traumatic brain injury, which we evaluate under neurocognitive disorders (12.02).

**The ‘A’ Criteria of 12.15 is much more specific:** Medical documentation of all of the following is required:

- 1. Exposure to actual or threatened death, serious injury, or violence;
- 2. Subsequent involuntary re-experiencing of the traumatic event (for example, intrusive memories, dreams, or flashbacks);
- 3. Avoidance of external reminders of the event;
- 4. Disturbance in mood and behavior; and
- 5. Increases in arousal and reactivity (for example, exaggerated startle response, sleep disturbance).

In my experience, many, many people who are significantly impacted by trauma will often not be diagnosed with PTSD and while they have many symptoms included in the description of trauma related disorders their records will not document all of the ‘A’ criteria of 12.15. When I do have a clear cut PTSD listing level condition, it is often for a claimant who is younger and so less time has elapsed between the trauma exposure and disability claim. Or, I may have an older client who has recent, adult trauma, or has remote trauma, recently accomplished clean time, and is relatively newly engaged in mental health care. This is because, as previously mentioned, trauma is often not asked about, not documented, not treated. Especially when working with adults in their 40s, 50s and above, I find that many have survived serious and complex childhood trauma but have lived most of their adult lives in unstable housing or homeless, in and out of treatment programs and the criminal justice system, and have often using street drugs to cope/medicate more than relying on prescribed medication. A recent client explained her heroin habit to me by describing how her prescribed medication was never strong enough to make her not feel things, heroin she could use, and use again –self dose—when her emotional state was intolerable. Her trauma history included complex trauma and polyvictimization. As is often the case, the only diagnosis of record was depression and some anxiety related symptoms. Trauma research helped to build the case that her depression, though only episodically treated, was more

intractable and treatment resistant due to her complex trauma history. Sample language that can be used in a legal arguments follow.

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**Sample 1. Ms. Green's psychological symptoms are so severe they meet or equal Listing 12.15 Trauma and stressor related disorders.** Ms. Green's symptoms include depressive symptoms (sad mood, constricted affect, hopelessness, crying, irritability, suicidal ideation, sleep disturbance, lack of interest, low energy), and anxiety related symptoms including nightmares, flashbacks, anxious mood, panic attacks, unstable moods, racing thoughts, paranoia, anger and related outbursts including homicidal ideation. Because of the range of her symptoms, Ms. Green's condition can be evaluated under Listing 12.04 Depressive, bipolar and related disorders, Listing 12.06 Anxiety disorders, and Listing 12.15 Trauma and stressor related disorders. A consistent feature or component of Ms. Green's severe symptoms is their root in childhood trauma including sexual abuse and assault by her step-father and verbal abuse throughout her life (cites). Moreover, her Fibromyalgia and chronic pain is likely related to her history of trauma and acute mental anguish and anxiety related to trauma, either as a manifestation of her mental pain or as a way of avoiding/dealing with her mental anguish. Thus, her condition most closely aligns with Listing 12.15 for Trauma and stressor related disorders. The medical evidence of record, summarized in detail below, establishes medical documentation of the 'A.' Criteria including: 1) exposure to actual or threatened death, serious injury, or violence (in her case sexual abuse and assault by her step-father); 2) subsequent involuntary re-experiencing of the traumatic event (dreams and flashbacks); 3) Avoidance of external reminders of the event (she avoided reporting abuse until the age of 19, and has difficulty sharing it with providers (Ex. 7F-19; Ex. 35F at 30); 4) Disturbance in mood and behavior (depression, anxiety, suicidal ideation and attempt); and 5) Increases in arousal and reactivity (sleep disturbance, paranoia, anger, "snapping" and "anger blackouts"). Moreover, as set forth fully below, Ms. Green's psychological symptoms result in marked limitation in her ability to concentrate, persist and maintain pace, and in her ability to adapt and manage her symptoms and maintain well-being in a work setting. Thus, Listing 12.15 A. and B. criteria is met or equaled.

**Sample 2: Childhood Trauma Results in Adult Depression that is More Intractable, Complex (in case involving sporadic treatment, significant substance use, no PTSD dx)**

The medical evidence of record establishes that Ms. Coe’s mental health condition—with depressive and anxiety related symptoms—results in marked limitations in several areas essential to work. She has been diagnosed with and treated for chronic depressive and anxiety related symptoms since 2013, alternately diagnosed as Mood Disorder and Major Depressive Disorder (Ex. 10F at 439, 429, 423, 413); Persistent Depressive Disorder (Ex. 5F-4), and Bipolar Disorder (Ex. 7F-126, 84; Ex. 10F-404, 393) as well as an Anxiety Disorder (Ex. 8F-10, , Ex. 2F at 14, 17-18) . Although Ms. Coe’s symptoms appear to have worsened in 2013, she has also consistently reported her first mental health intervention at the age of 8, possibly related to her report of childhood sexual abuse at the age of 5 and physical abuse. See, Ex. 10F at 437-438; Ex. 5F-2. She has reported trying to get disability benefits since 2009 (and in fact did apply in July, 2009) (Ex. 10F-43; Ex. 1E-1), has a high range of the lifetime General Victimization Scale (Ex. 8F-16) and, as recently as April, 2017, Ms. Coe scored high in the Internal Mental Distress Scale (Ex. 8F-10) and in addition to depressive symptoms, endorsed a “constellation of symptoms” including excessive worry and anxiety, re-experiencing traumatic events, and recurrent, unexpected panic attacks (Ex. 10F at 402)—which, according to examining Psychiatrist Dr. Moore--cause “significant distress or impairment in functioning”. Ex. 10F-402.

The existence of a strong relationship between early childhood trauma and subsequent depression is now well established (Putnam, 2003). Recent twin studies, considered one of the highest forms of clinical scientific evidence because they can control for genetic and family factors have conclusively documented that early childhood trauma, especially sexual abuse, dramatically increases risk for major depression, as well as many other negative outcomes. **“Childhood trauma appears not only to increase risk for Major Depression but also to alter the course of illness in ways that contribute to a poorer prognosis.”** (emphasis added). See, Complex Trauma in Children and Adolescents—The National Child Traumatic Stress Network (NCTSN), pp. 12-13. White paper from the NCTSN funded by Substance Abuse and Mental Health Services Admin., U.S. Department of Health and Human Services. 2003. Ms. Coe’s depressive disorder is grounded in childhood trauma and consistent with research and as documented in the longitudinal record, her symptoms have proven severe and intractable.

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**Trauma and Residual Functional Capacity—Step 4**

Again, because of the high rates of physical and behavioral health comorbidities among persons impacted by trauma, you should be able to prove that serious physical and mental impairments,

grounded in and/or related to child and/or adult trauma exposure, results in marked to severe limitations in several areas essential to work. SSR 85-15 is a helpful ruling to apply in these cases as it specifically describes how persons with mental impairments may be limited in their ability to meet the mental demands of work, including responding well to others, dealing with change, and coping with stress.

**Sample 1: Mental and Physical Impairments Grounded in Trauma:** Ms.

Blue's myriad and chronic mental impairments that include mood and trauma related symptoms, personality and possible learning disorder, combined with her chronic back and hip pain, result in a residual functional capacity that precludes sustained work at any exertional level. Specifically, Ms. Blue's mental health impairments –with mood and trauma related symptoms--result in marked limitations in her ability to understand, remember and apply information, to maintain concentration, persist on tasks for extended periods and work at an acceptable pace, to adapt to changes in a work environment and manage even minimal work stress, and to complete a normal work day and work week without interruption from psychological symptoms.

In determining mental residual functional capacity, SSR 85-15 is key. It provides in relevant part as follows:

Where a person's only impairment is mental, is not of listing severity, but does prevent the person from meeting the mental demands of past relevant work and prevents the transferability of acquired work skills, the final consideration is whether the person can be expected to perform unskilled work. **The basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions; to respond appropriately to supervision, coworkers, and usual work situations; and to deal with changes in a routine work setting. A substantial loss of ability to meet any of these basic work-related activities would severely limit the potential occupational base.** This, in turn, would justify a finding of disability because even favorable age, education, or work experience will not offset such a severely limited occupational base.

Example 1: A person whose vocational factors of age, education, and work experience would ordinarily be considered favorable (i.e., very young age, university education, and highly skilled work experience) would have severely limited occupational base **if he or she has a mental impairment which causes a substantial loss of ability to respond appropriately to supervision, coworkers, and usual work situations.** A finding of disability would be appropriate.

Here, Ms. Blue's mood instability with pressured speech and thought, by its very nature, would interfere with her ability to understand, remember and apply information, concentrate, persist and maintain pace and complete a normal work week and work day without interference from psychological symptoms. Symptoms related to her diagnosis of Personality Disorder would markedly interfere with Ms. Blue's ability to adapt and manage herself in a work setting and maintain a full-time work schedule. The impact of trauma—anxiety, hypervigilance, panic, avoidance and flashbacks—would all interfere with Ms. Blue's ability to concentrate, persist and maintain pace and to remain in a job setting on a daily and weekly basis. A learning disability would further diminish Ms. Blue's ability to understand, remember and apply information on a day to day basis. As per Dr. Levitan, although Ms. Blue could understand and carry out instructions she could not be relied upon to remember them the following day. See, Ex. 15F-4. Ms. Blue's mood lability and trauma related symptoms have resulted in her lifelong dependence on others and chronic use of substances to cope with her emotions and experience. She would be unable to effectively adapt to work situations or to respond appropriately to supervision of her work and person.

Moreover, in evaluating the impact of a mental impairment on the ability to work, the impact of stress must be considered. SSR 85-15 provides guidance on the impact of stress on the ability to sustain simple work:

The reaction to the demands of work (stress) is highly individualized, and mental illness is characterized by adverse responses to seemingly trivial circumstances. The mentally impaired may cease to function effectively when facing such demands as getting to work regularly, having their performance supervised, and remaining in the workplace for a full day. A person may become panicked and develop palpitations, shortness of breath, or feel faint while riding in an elevator; another may experience terror and begin to hallucinate when approached by a stranger asking a question. Thus, the mentally impaired may have difficulty meeting the requirement of even so-called "low stress" jobs.

In a way Ms. Blue has survived stressful events far beyond what she would face in a work setting. However, she has coped with stress by chronic use of cocaine, dependence on others and powerful (for the most part prescribed) psychotropic medication, with very sedating side effects. Dr. Levitan opined that Ms. Blue would have difficulty handling mild to moderate work pressure and stress. The longitudinal record shows that at age 44, Ms. Blue would be unable to tolerate even the most minimal work stress—the “coping skills” she expressed her need for back in 2004, (Ex. 2F-2) still remain out of reach. The hypervigilance she experiences as part of her PTSD would cause her to overreact to work related stress. Her varied and chronic symptoms would not allow her to manage stress

well enough to keep a regular schedule, be at work on time and remain in the work place all day.

In addition, Ms. Blue's chronic pain, side effects from medication and asthma cause additional exertional limitations. Ms. Blue's chronic back and hip pain is also severe; it limits her ability to sit, walk and stand for long (Ex. 5E-6) and precludes physically demanding work. Ex. 5E. She reports and records reflect that her chronic hip and back pain stems from a physical assault by an abusive boyfriend many years ago. Ex. 10F-182. Her boyfriend tied her up for three days and beat her in the body and head, with loss of consciousness. She spent 6 days at St. Mary's for enlarged lungs, and her boyfriend went to jail for 8 years. Ex. 3F-4. Records regarding back pain date back to 2008 when she was incarcerated and needed a low bunk due to back pain. Ex. 4F-28. She could not walk and stand for more than several hours in a work day. In 2010 she "couldn't sit due to the nerves in her back" and she was treated for back pain during prenatal visits. Ex. 10F-182, 187. Between January and December, 2016, Ms. Blue also had about ten visits at Rush, Stroger and UIC Emergency Departments for chronic complaints of pain—myalgias and headaches, back pain and hip pain. (cites). In August, 2016 MRI results from Rush ER showed degenerative changes.... Ex. 16F-26. Although Ms. Blue's frequent presentation to emergency rooms and her demand for narcotic pain medications raised concern for drug seeking behavior, she was also consistently evaluated and treated for chronic lumbar pain. In addition, in 2017 and 2018 Ms. Blue has continued to be treated for chronic back pain with non-narcotic pain medications including Flexeril and Decadron (Ex. 19F-119, 129; Ex. 20F-24) and as of February, 2018, even Norco. Ex. 20F-15. Ms. Blue could not stand, walk or even sit for extended periods, her medications cause drowsiness and her asthma restricts her from working around temperature extremes or chemicals or other irritants.

The functional impairments caused by Ms. Blue's mental and physical conditions results in a residual functional capacity that precludes even simple, unskilled work on a full-time, sustained basis, and has since her application date. Thus, a finding of disabled is warranted at Step 5 of the sequential process.

**Sample 2—RFC involving Somatic Symptoms/Trauma:** Ms. Jane's frequent complaint of pain and other symptoms such as headaches, memory loss, vomiting, swollen body parts, blurred vision, shortness of breath and dizziness (Ex. 6F-10) may also be rooted in or exacerbated by anxiety and/or her history of trauma. In the late Fall of 2014 she also reported symptoms of derealization (Ex. 9F-5) and recently had intensifying PTSD symptoms including instances of flashbacks coupled with AH/VH/Tactile hallucinations. Ex. 11F-73. As of April 2015 she also had possible dissociative episodes when she was "spacing out" and losing track of time and place. Ex. 11F-73. Ms. Jane was urged to contact the YMCA for long term, trauma focused therapy. Ex. 11F-73. She was assessed with PTSD, with a GAF of 40.

Here, the medical evidence as a whole indicates Ms. Jane would be unable to tolerate work stress of even a simple, unskilled, job. There is undoubtedly a connection between Ms. Jane's physical health impairments (COPD, Seizures and Migraines) and her depressive and anxiety disorders. Her poor health exacerbates her mental health, and her mental health conditions, rooted in severe childhood trauma, clearly impact her physical health and well-being. Even simple, unskilled work is beyond Ms. Jane's physical and mental capacity at this time and has been since her application date of March 12, 2013. As stressed recently by her psychotherapist, Ms. Jane needs long term, trauma focused therapy. Ex 11F-73.

**Sample 3: Trauma and Managing Stress:** Ms. Doe herself has reported she does not handle stress well at all (Ex. 5E-7) which is very consistent with her report that she has not received any help related to the high rate of traumatic events she has endured throughout her lifetime including physical assault, assault with a weapon, sexual assault, other unwanted or uncomfortable sexual experience as well as witnessing physical assaults, life threatening illness or injury to others and other stressful events/experiences. Ex. 8F-16. These experiences, as well as her long history of homelessness (documented in the record since at least 2013) and her history of "using substances to forget about traumatic memories" (Ex. 8F-15) suggest that Ms. Doe, now in her 50's, simply lacks the emotional reserves to adapt to stress. Ms. Doe's depressive and anxiety related symptoms result in marked limitation in her ability to maintain attention and concentration for extended periods, to perform activities within a schedule, maintain regular attendance or be punctual within customary tolerances. In addition, consistent with SSR 85-15, she would be unable to successfully manage work related stress. Thus, her residual functional capacity precludes the performance of even simple, unskilled work on a full-time, sustained basis.

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## **SSR 13-2p --Determining the Materiality of Drug Abuse or Alcoholism (DAA)-Step 6**

The 1996 statutory change that terminated SSI/SSDI eligibility for individuals whose drug addiction or alcoholism is **material to their disability *was not intended to disqualify persons who have disabling co-occurring impairments.*** Nevertheless, it has. SSI/SSDI Programs have been rendered inaccessible to many eligible persons whose symptoms of SMI and substance use are hopelessly entangled. As a result, persons with severe mental impairments and trauma exposure are unable to secure resources essential to exiting homelessness, stabilizing in the community and improving their physical and mental health.

Dr. Daniel Sumrok, director of the Center for Addiction Sciences at the University of Tennessee Health Science center's College of Medicine (the first center to receive the Center of Excellence designation from the Addiction Medicine Foundation and one of the first physicians to become board-certified in addiction medicine) has said:

Addiction shouldn't be called "addiction". It should be called "ritualized compulsive comfort-seeking."

Ritualized compulsive comfort-seeking (what traditionalists call addiction) is a normal response to the adversity experienced in childhood, just like bleeding is a normal response to being stabbed.

The solution to changing the illegal or unhealthy ritualized compulsive comfort-seeking behavior of opioid addiction is to address a person's ACEs individually and in group therapy; treat people with respect; provide medication assistance in the form of buprenorphine, an opioid used to treat opioid addiction; and help them find a ritualized compulsive comfort-seeking behavior that won't kill them or put them in jail.<sup>66</sup>

Social Security Claimant's representatives can contribute to the cause of treating people with respect and empowering persons to engage in meaningful behavioral health care by securing benefits for persons who have used substances to seek comfort from adversity.

**SSR 13-2p, addresses the materiality of substance use disorders to the determination of disability, and an excerpted sample legal argument is included.** Because of the high rates of substance use among persons impacted by trauma, it is a critically important tool for the trauma informed advocate. Advocates should be very familiar with SSR 13-2p, which explicitly:

- does NOT require any period of abstinence to establish that substance use is not material to disability.

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<sup>66</sup> [www.acestoohigh.com/2017/05.02](http://www.acestoohigh.com/2017/05.02).

- Actually contemplates that some people use drugs or alcohol to lessen they symptoms of their other impairment(s) and that a claimant’s symptoms may worsen in the absence of drugs or alcohol. SSR13-2p, FN 15.

I consider SSR 13-2p to be useful and helpful at integrating trauma awareness to a legal case. Often people who are impacted by trauma and toxic stress have illness, substance use and low function for so long that DAA will be found *not to be material to the determination of disability* as “the record is fully developed and the evidence does not establish that the claimant’s co-occurring mental disorders would improve to the point of non-disability in the absence of DAA.” See, SSR-13-2p, Question 7.d. A sample legal argument regarding DAA in the context of trauma history is provided below.

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### **Sample 1. Substance Dependence—Grounded in Childhood Trauma-- is Not Material to Mr. Brown’s Disability**

The Social Security Administration’s policy on how to consider whether substance abuse or dependence is a contributing factor material to the determination of disability is set forth in Social Security Ruling 13-2p. This SSR sets forth a six step process to make this determination: 1) does the claimant have a medically documented alcohol or substance abuse or dependence diagnosis; 2) is the claimant disabled considering all the impairments; 3) is DAA the only impairment; 4) is the other impairment disabling by itself when the claimant is dependent upon or abusing drugs or alcohol; 5) does the substance abuse or dependence cause or affect the claimant’s medically determinable impairment; 6) would the other impairment/s improve to a point of non-disability in the absence of DAA?

First, because medical evidence of alcohol and cannabis abuse exists during the pendency of Mr. Brown’s application for SSI disability benefits, a “DAA determination” must be made.

Second, as set forth previously, Mr. Brown’s depressive disorder is disabling.

Third, substance dependence is not Mr. Brown’s only impairment. Rather, it is an additional co-occurring disorder. Mr. Brown has consistently been diagnosed with an Axis I Mood disorder, most frequently Major Depressive Disorder, since as early as 2008.

Fourth, as discussed previously, Mr. Brown’s mental impairments are disabling while he abuses alcohol and marijuana.

Fifth, Mr. Brown’s depressive disorder is likely affected by his substance use, although after such long term, chronic use, it is difficult to say to what degree. Alcohol Use Assessments completed by Thresholds in 2013 document ongoing symptoms and functional impairments related to Mr. Brown’s substance use. A Substance Abuse

Context Assessment dated October 7, 2014 explored Mr. Brown's motive for alcohol use which included: helping his body to feel relaxed and take his mind away from his problems, while drugs (marijuana) helped to increase his appetite and help him to feel relaxed. Ex. 41F-354; see also, Ex. 19F-2 ("easier not to feel anything at all"). Disadvantages to using substances included lack of motivation, putting important things on the back burner, and feeling physically ill. Id. From Mr. Brown's perspective at least, alcohol and marijuana use has been a coping mechanism that has reduced his anxiety and offered at least a temporary reprieve from his chronic depressive symptoms of feeling hopeless and worthless.<sup>67</sup>

The sixth step "includes some of the most complex cases for the *DAA materiality* analysis" (SSR 13-2p, Question 7. a.), determining whether Mr. Brown's depression and anxiety symptoms would improve to a point of nondisability in the absence of substance abuse. The ruling provides:

We do not know of any research data that we can use to predict reliably that any given claimant's co-occurring mental disorder would improve, or the extent to which it would improve, if the claimant were to stop using drugs or alcohol.

SSR 13-2p, Question 7. a.

It further provides that:

**To support a finding that DAA is material, we must have evidence in the case record that establishes that a claimant with a co-occurring mental disorder(s) would not be disabled in the absence of DAA.**

SSR 13-2p, Question 7. b.

And finally,

We will find that DAA is not material to the determination of disability and allow the claim **if the record is fully developed and the evidence does not establish that the claimant's co-occurring mental** disorders would improve to the point of nondisability in the absence of DAA.

SSR 13-2p, Question 7. d.

In Mr. Brown's case, the evidence does not establish that Mr. Brown's depressive and anxiety disorders would improve to the point of non-disability in the absence of use.

First, the early onset of Mr. Brown's trauma related and depressive symptoms including avoidance and substance use suggests that his condition would not improve to a point of

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<sup>67</sup> Note that SSR 13-2p, at FN 15, acknowledges that in some cases, people use drugs or alcohol to lessen the symptoms of their other impairments(s).

nondisability now, almost 40 years later, even with complete and long-term abstinence. Mr. Brown first recalled the painful circumstances of being raised by an unstable, mentally ill mother in 2009, during his second hospitalization at Tinley Park where he was taken after becoming suicidal after being turned away while trying to visit his mom in a nursing home. Ex. 5F at 27-28. He reported that his mother had been diagnosed with paranoid schizophrenia and while not physically abusive she exhibited bizarre/paranoid behavior such as screaming at the neighbors and accusing them of trying to hurt her. Ex. 5F-28. He “basically stayed in 7<sup>th</sup> grade for three years because he “stayed at home, didn’t go to school, [his] mother didn’t care.”” Ex. 7F-51. In addition to this sort of psychological trauma and neglect, his mother also permitted and even encouraged him to start drinking beer at age 11 or 12. Mr. Brown has also reported his father “was not loving”, had divorced his mom when he was three and he had little contact with him since then. Ex. 5F-15. Mr. Brown has consistently reported being unable to motivate himself to attend school as a child, recently reporting “abuse as a kid by bullies who would beat him up”, and his mother’s mental illness that had a negative effect on him. Ex. 53F-38.

Psychiatric staff at Elgin MHC opined that his psychosocial history indicated that Mr. Brown’s *psychological development, being raised in an environment where he was not cared for appropriately, may contribute to his symptoms.* Ex. 5F-17. The evidence bears this out. Mr. Brown’s feelings of worthlessness and hopelessness are deeply embedded, chronic and self-destructive. For example, in a couple of hospitalizations in 2008 and 2009 he was assessed with psychotic symptoms of hearing voices because of his report of auditory hallucinations telling him he has no business living and “telling [him] I’m no good and a piece of shit and don’t deserve to live anymore.” Ex. 4F-2; 1F-80. In subsequent hospitalizations when this was further explored it was determined that this “voice” was not an actually a psychotic process but Mr. Brown’s own voice in his head, constantly saying things like “What are you gonna do with your life, you’re no good for this society.” Ex. 5F-13. He has also reported feeling “guilty” because “haven’t worked in my life”, that life was worthless, hopeless--“my life is an accident” (Ex. 1F-21, 25). He was described as feeling very helpless and very worthless “for not doing nothing with my life, pissing my life away” and hopeless “I don’t care about society because society don’t care about me, because I’m a piece of shit...I’d be better off under the ground.” Ex. 7F-47. Thirty years of Mr. Brown’s excessive guilt, feelings of worthlessness and lack of positive coping skills will not go away or improve to a point of nondisability even with extended sobriety. Dr. Amdur was “very impressed with the history of either severe depression or phobic avoidance beginning in childhood”-- a fact that suggested to Dr. Amdur that *Mr. Brown would continue to manifest markedly severe symptoms of depression and anxiety disorder in the absence of use.* See, Ex. 54F-6.

Further evidence that substance use is not material is that there are several extended hospital stays where Mr. Brown was clean/sober for a significant time and treated with medication, yet still manifest symptoms of depression and isolation. ...

Thus, because the record is fully developed and there is no evidence that Mr. Brown's Major Depressive illness would improve to the point of non-disability in the absence of use, substance use is not material to Mr. Brown's disability.

**Sample 2:** Fourth, as discussed previously, Mr. Green's mental impairments are disabling while he is dependent upon opiates.

Fifth, Mr. Green's bipolar and trauma related disorder is likely affected by his substance use, although with its early onset (he was just 8 years old when his mother began dosing him with heroin to curb his hunger) and such long term, chronic use, it is difficult to say to what degree. Research has shown that the more avoidant or arousal/reactivity symptoms an individual with PTSD has the more likely he is to develop an Opioid Use Disorder. An increase in DSM-5 avoidance and arousal/reactivity symptom clusters is associated with a 100% higher odds of having an Opioid Use Disorder for men. These findings suggest that opioid abuse is motivated by a desire to avoid trauma-related stimuli and numb or cope with heightened physiological arousal. Smith, Kathryn, Philip Smith, Sarah Cercone, Sherry McKee, and Gregory Homish, "Past year non-medical opioid use and abuse and PTSD diagnosis: Interactions with sex and associations with symptom clusters," *Addictive Behaviors* 58, (2016): 167-174, <https://dx.doi.org/10.1016%2Fj.addbeh.2016.02.019>. This is consistent with Mr. Green's description about how and why he has used opiates and his myriad and so far unsuccessful attempts to abstain from use. Thus, it's difficult to say whether Mr. Green's opiate use worsens or actually mitigates his trauma related symptoms by muting their effects and improving his ability to cope with acute psychological distress.

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### **SSR 16-3p: Evaluation of Symptoms in Disability Claims—how evidence of trauma exposure and its impact can strengthen evidence and reconcile “inconsistencies”**

SSR 16-3p addresses the extent to which an individual’s symptoms can reasonably be accepted as consistent with the objective medical and other evidence of record. Available research strengthens the argument that a medically determinable impairment, grounded in trauma, could “reasonably be expected” to produce the symptoms. Research further shows that the intensity and persistence of symptoms experienced by someone impacted by trauma are likely to be severe, long-lasting and lead to disruption of learning and work and contribute to disability

SSR 16-3p provides, in relevant part:

Subjective symptom evaluation is not an examination of an individual’s character or truthfulness. Rather, adjudicators must limit their evaluation to the individual’s statements about his or her symptoms and ALL the evidence in the record that is relevant to the individual’s impairments.

**Does the nature, intensity, frequency, or severity of an individual’s symptoms impact their ability to work?**

To determine if someone is disabled, SSA considers all of the individual’s symptoms, including pain, and **the extent to which the symptoms can reasonably be accepted as consistent with the objective medical and other evidence in the claimant’s record.**

**“Symptom” is defined: the individual’s own description or statement of his or her physical and mental impairment/s.** Under SSA policy, a person’s statement of symptoms alone are not enough to establish the existence of a physical or mental impairment or disability.

1) **MUST** be medically determinable impairment (MDI) that could reasonably be expected to produce the individual’s symptoms. SSA does NOT consider whether the severity of an individual’s alleged symptoms is supported by the objective medical evidence. **Rather, if there is MDI that “could reasonably be expected” to produce the symptoms, it moves to step 2:**

2) SSA evaluates the intensity and persistence of an individual’s symptoms and determines the extent to which an individual’s symptoms limit his or her ability to perform work related activities. (e.g. B. and C. criteria of Mental Impairments Listings, and/or MRFC).

- In doing so, will consider ALL evidence in case record, including the objective medical evidence; an individual’s statements about the intensity, persistence and limiting effects of symptoms; statements and other information provided by medical sources and other persons; and any other relevant evidence in the individual’s case record-including whether the individual has attempted to seek treatment for symptoms and to follow treatment once it is prescribed.<sup>68</sup> “Persistent attempts to obtain relief from symptoms, such as increased dosages and changing medications, trying a variety of treatments,

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<sup>68</sup> This would include information about ACEs and trauma exposure contained in the medical or other evidence of record.

referrals to specialists or changing treatment sources may be an indication that an individual's symptoms are a source of distress and may show that they are intense and persistent.”

- If frequency or extent of treatment sought is not comparable with the degree of the individual's subjective complaints, or if the individual fails to follow prescribed treatment that might improve symptoms, SSA may find an individual's symptoms inconsistent with the evidence of record BUT WE WILL NOT FIND THIS WITHOUT considering possible reasons why claimant may not comply with treatment or seek treatment consistent with the degree of his or her complaints. The possible reasons why a claimant may not have pursued treatment that SSA will consider include (but is not limited to) (in relevant part):
  - An individual may have structured his or her activities to minimize symptoms to a tolerable level by **avoiding**<sup>69</sup> physical activities or mental stressors that aggravate their symptoms;
  - Side effects of RX may be intolerable;
  - Individual's symptoms may be relieved with over the counter medications<sup>70</sup>
  - Due to various limitations (such as language, or mental limitations), an individual may not understand the appropriate treatment for or need for consistent treatment<sup>71</sup>
  - Due to a mental impairment (for example, those that affect judgment, reality testing or orientation).

At the end of the day, every Social Security disability claim is determined by the persuasiveness of the evidence—whether the longitudinal information, record of treatment and functional information is consistent, credible, and convincing. SSR 16-3p provides several openings to address how trauma exposure impacts the nature, intensity, duration and severity of symptoms related to physical and mental impairments. It reiterates that SSA will consider ALL evidence in the case record in determining symptom severity (which would include trauma exposure) and is especially useful in cases when the treatment record does not appear to be comparable to the claimant's subjective complaints. Under SSR 16-3p SSA will consider that someone may have structured their lives or activities to manage symptoms by avoiding stressors that aggravate their

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<sup>69</sup> Avoidance is a common response to/symptom related to trauma. People may avoid treatment to avoid talking about it.

<sup>70</sup> Or alcohol or illegal drugs—High ACE relate to addiction: Compared with people who have zero ACEs, people with ACE scores are two to four times more likely to use alcohol or other drugs and to start using drugs at an earlier age. People with an ACE score of 5 or higher are seven to 10 times more likely to use illegal drugs, to report addiction and to inject illegal drugs. [www.acestoohigh.com](http://www.acestoohigh.com).

<sup>71</sup> Many people do not recognize the impact ACEs and adult trauma has on their physical and mental health until late in life—if ever—thus they might not seek treatment or understand need for treatment.

symptoms (this could include avoiding therapy that necessitates talking about/dealing with past trauma) and also recognizes that some symptoms may be relieved by such things as over the counter medications (or, by extension, use of etoh or illicit substances or even prescription narcotics to mute mental distress). Thus, think of SSR 16-3p when the medical evidence of record, during the relevant time period, seems less than compelling. For example, in Ms. Blue's case (Sample 1 in the earlier section addressing RFC-Step 4), the only medical evidence of record since her SSI application date was frequent ED visits for narcotic pain relievers related to chronic back pain and one DDS consultative psychological evaluation. The records also indicated she was using cocaine several days a week. She had not been in outpatient mental health care during the pendency of her application because her last provider had refused to continue prescribing the high dose of Thorazine that my client found essential to managing her symptoms. This client could well describe her past challenges at finding a medication regimen that treated her symptoms without intolerable side effects. She also found the idea of talking about and processing her trauma intolerable. ED records documented her prior diagnoses of mood disorder and referenced past psychiatric medications but also noted her drug seeking behavior. However, we were able to meet our burden of proof by developing the longitudinal evidence (that included inpatient psychiatric hospitalizations, prison records, and outpatient treatment), and documenting a compelling claim involving severe and persistent mental and physical health impairments rooted in profound childhood and additional adult trauma.

Thus, SSR 16-3p is a helpful resource to trauma informed advocates to address what may at first appear to be weaknesses or gaps in the evidence and to present a coherent and compelling explanation about how the medical and functional impairment evidence is wholly consistent with trauma exposure, trauma research and your client's disabling impairments.

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## **Conclusion**

In closing, understanding how ACEs and trauma impacts the health and well-being of low income clients and communities creates a paradigm shift in how we provide legal services and pursue legal solutions for our clients. As medical and interdisciplinary research continues, lawyers and advocates are well situated to explore the possibilities of integrating a trauma informed approach and trauma awareness into Social Security disability law, practice and policy.



## **Presenter Bio**

Attorney Lisa Parsons has devoted her career to working on behalf of persons who are homeless and impacted by mental illness. She is one of the nation's foremost experts in trauma-informed legal care. She has led Illinois' first behavioral health MLP since 2007, bringing it to the Legal Council in January 2014. Lisa and her team conduct outreach on the streets, in shelters, and in partnership with behavioral health providers to assist homeless individuals with co-occurring disorders to secure Social Security disability benefits and connect them to healthcare, housing, and supportive services. She also serves on the Chicago SOAR (SSI/SSDI Outreach Access and Recovery) Steering Committee. After earning her law degree, she served as project director of the Bar Association of San Francisco's Homeless Advocacy Project, before accepting a similar position at Legal Assistance Foundation of Chicago (LAF). She later directed a joint law and social services project at the University of Chicago's Mandel Legal Aid Clinic to assist persons with serious mental illness to secure services in the least restrictive environment, obtain disability benefits, and defend against discrimination in housing. In 2004, Lisa researched and produced two reports for the Lawyers Trust Fund of Illinois on public benefits and housing law issues affecting low-income households. She is a graduate of the University of California Hastings College of the Law.

## **Agency Background**

Legal Council for Health Justice uses the power of the law to secure dignity, opportunity, and well-being for people facing barriers due to illness and disability. All programs partner with health and hospital systems to train and support the care provider network, provide direct representation to referred patients, and conduct systemic advocacy to promote health equity among populations facing chronic, disabling, and stigmatizing health and social conditions. [www.legalcouncil.org](http://www.legalcouncil.org)