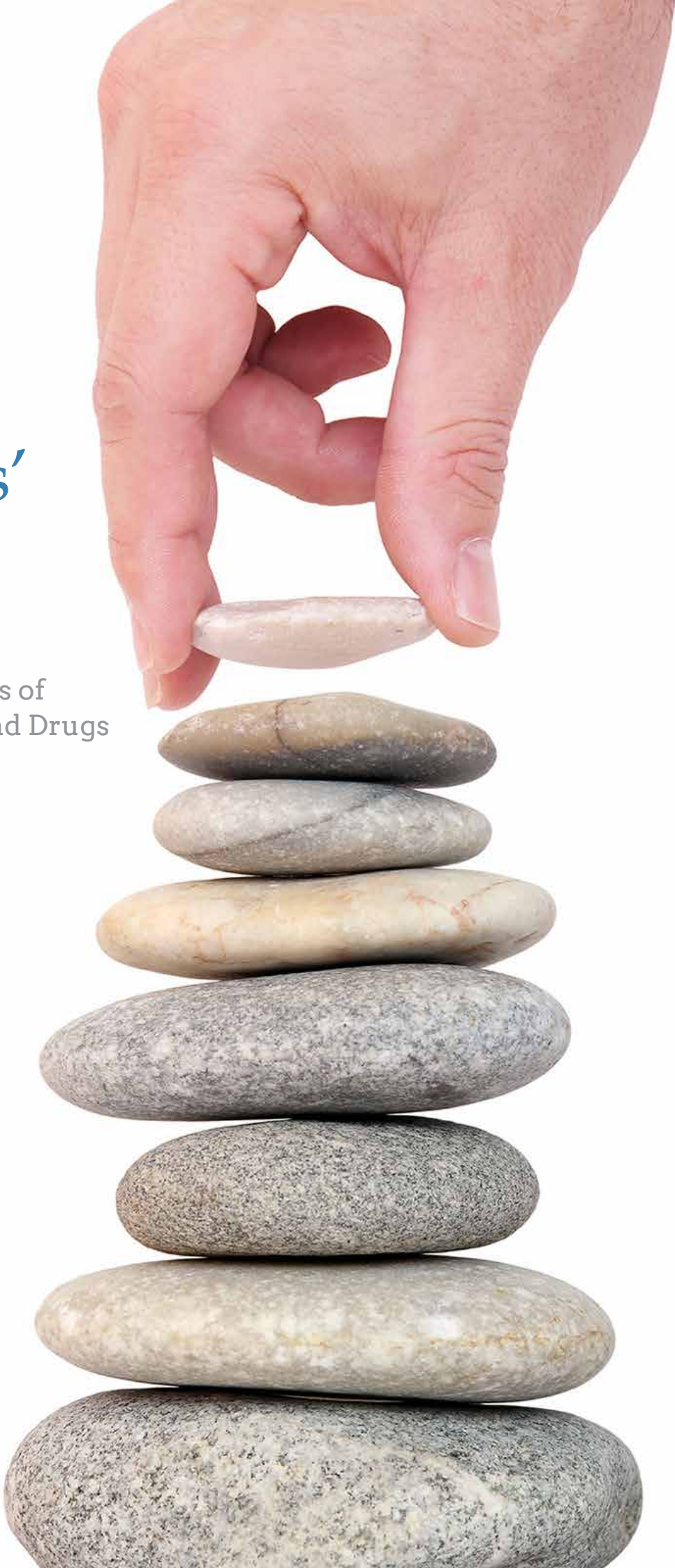
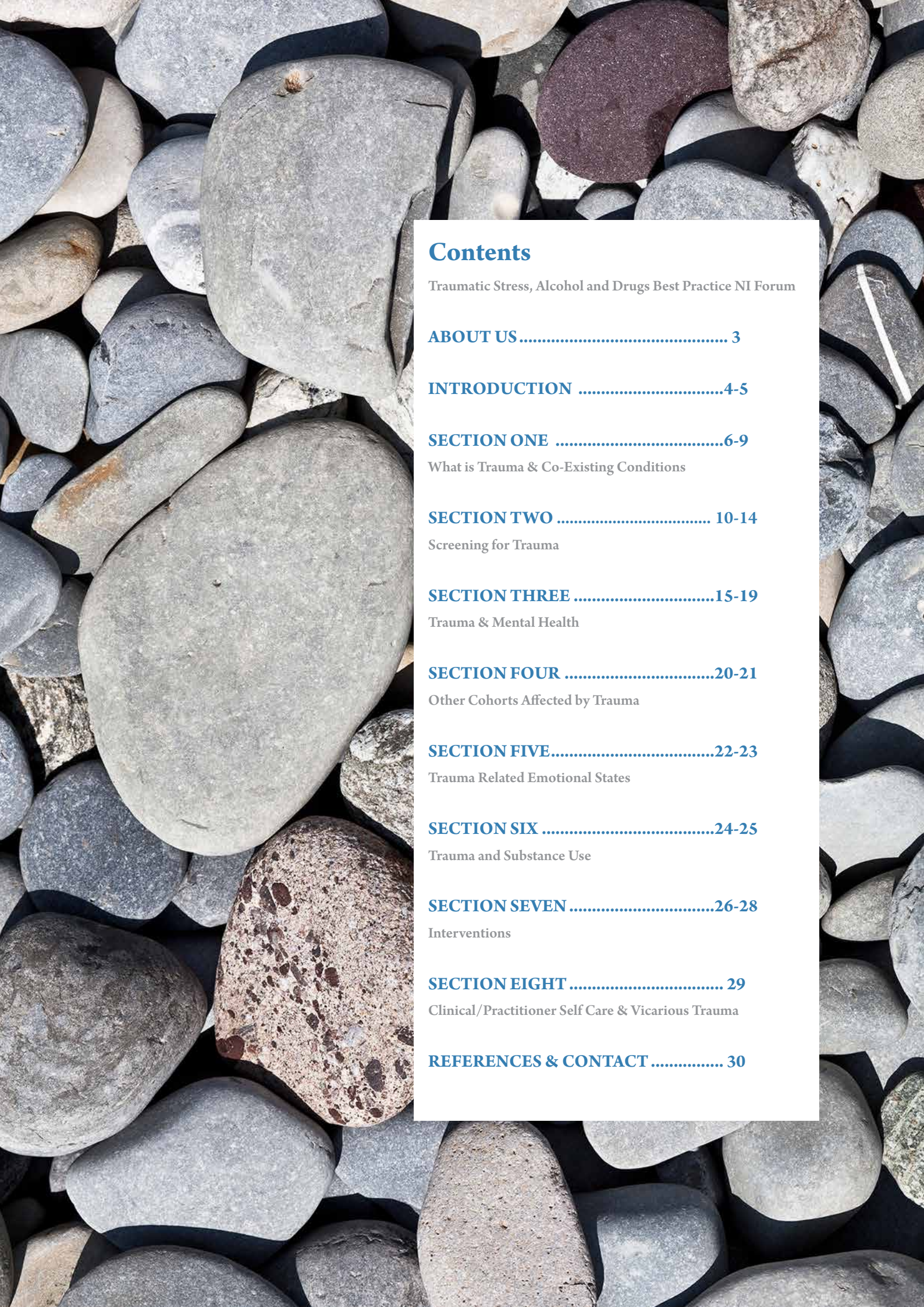
Practitioners' Resource & Guide

in the Co-Existing Conditions of
Traumatic Stress, Alcohol and Drugs





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Traumatic Stress, Alcohol and Drugs Best Practice NI Forum

About Us

The Forum is the outcome from a Cross-Sectoral response to the enduring Legacy of Trauma. Originating in 2012 the Forum has gathered research, facilitated public workshops and held a number of conferences. Feedback from Practitioners is that the Forum provides a space to articulate the challenges these complex issues present and facilitates networking and communication across the Sectors as well as between Practitioners and Service Users.

The Forum has come from a demand momentum with Principles to create space for networking; sharing experience and knowledge, enhancing best practice with a holistic approach, practical outcomes and service user ethos. It exists because of this demand by practitioners for a peer led learning environment that respects their diverse working conditions, whilst supporting their collective aspirations towards identifying Best Practice and developing more effective ways of helping. Some of the objectives include:

- To begin to develop a common understanding among Forum participants on best practice on these co-existing conditions
- To review principles of practice for service providers
- To establish resources for effective practice in this busy and complex area
- The understanding how trauma affects the emotional, behavioural, cognitive, social, and physical functioning and its relationship to Alcohol and Drug Misuse can not only improve services, but also to help re-build lives. Exposure to trauma, whether it is a single event, or multiple incidents, is a pervasive issue that significantly impacts the health and well being of an individual and society.

AOD: Alcohol and Other Drugs

ASD: Acute Stress Disorder

CBT: Cognitive Behaviour Therapy

CO-EXISTING CONDITIONS: Trauma and Substance Misuse

DESNOS: Disorders of Extreme Stress Not Otherwise Specified

DID: Dissociative Identity Disorder

DSM: Diagnostic and Statistical Manuel of Mental Disorders

FORUM: Traumatic Stress, Alcohol & Drugs N.Ireland Best Practice Forum

GLBT: Gay, Lesbian, Bisexual, Transgender

HSC: Health and Social Care Trust

ICD: International Classification of Diseases

PTE: Potentially Traumatic Event

PTG: Post Traumatic Growth

PTSD: Post Traumatic Stress Disorder

SU: Substance Use

SERVICE USER: Title used rather than Patient or Client

SUD: Substance Use Disorder

SUDS: Subjective Units of Distress Scale

THE TROUBLES: The civil and political conflict from 1968 in Northern Ireland

WEBSITE: www.traumaalcoholanddrugs.hscni.net

Acknowledgements

We wish to thank and acknowledge the work of Picking up the Pieces booklet at Regen, Australia, that assisted us with the idea for this Resource and for some of the content.

Introduction

The Resource Guide's objectives and how to use it.

This Guide aims to develop the understanding for Service Providers across the Mental Health/Trauma and Alcohol & Drugs treatment, to create better shared understanding and inform effective recovery treatment pertaining to the Co-Existing Conditions of Trauma, Alcohol and/or Drugs. It is to help identify how trauma affects the emotional, behavioural, cognitive, social, and physical functioning and its interrelationship with Alcohol and Drug Misuse.

While this resource is targeted at Practitioners/Clinicians, it contains information that may be helpful for Service Users and their families working towards recovery from trauma related issues. This introductory resource aims to give clinicians clear direction and confidence when working in this area. It is however recommended that all Practitioners/Clinicians seek further education around specific trauma interventions.

It is not uncommon in many countries for Mental Health or AOD treatment to have been underway for some time before it becomes apparent (or it may not be identified) that a co-existing condition exists. However if it had been identified earlier, a treatment plan could have been developed that recognised the interplay of both conditions (described later in this Guide) and their treatment needs. Early recognition aids the development of the most useful possible treatment plan. The Guiding Principle must be that all people receiving Mental Health or AOD treatment services should be screened or assessed for Co-Existing Conditions. It is not intended that either Mental Health or AOD services should vary their primary criteria for entry to their service system. What is desirable is that all Service Uses who wish to engage in therapy and that meet the organisations own criteria are screened for co-existing conditions that will be routinely detected and assessed and an integrated treatment plan developed that addresses their more holistic needs.

By Trauma (PTSD) we have based our experiences in this Guide/ Resource on Trauma of the Troubles but it also encapsulates Trauma from Sexual Abuse, Physical Abuse and severe Emotional Abuse as well as Sudden Death/Traumatic Bereavement.

As a practitioner/ clinician, it is important that you recognise the effects of trauma so as to get treatment integrated with the client/ patients use of drugs and alcohol. Some people use alcohol and other drugs to manage the effects of trauma. This may appear to address symptoms initially but, as time goes on, the trauma sufferer accumulates additional problems associated with drug and alcohol use (see section one and from more details in the leaflet for individuals and families on our website).

Ongoing misuse of alcohol and other drugs can put users in situations that potentially compound trauma. Some examples include increased risk of assault and overdose. Experiencing trauma can have a number of effects that are not necessarily independent of each other. Either negative consequences or positive changes may be activated by an event that significantly shatters the individual's fundamental assumptions about themselves and the world. An example of a negative consequence is the onset of PTSD. A positive consequence would be post-traumatic growth (PTG), in which an individual reconstructs the self and reassesses their life and priorities in such a way that personal growth occurs. This can lead to positive changes.

Considerations for practitioners/clinicians in your role is that there are many ways you can assist a service user to recover from the psychological and other effects of trauma. It is important that addressing trauma is seen as a fundamental part of your treatment within a shared, collaborative care environment. Your role may include screening for traumatic stress; providing a safe and supportive environment within which the client can work and supporting transitions between and across services in a safe and cohesive manner. Understanding when to refer is crucial. If the client's symptoms are severe, with high levels of prolonged distress or significant impact on social and occupational functioning, you will need to refer to a specialist treatment provider. There are many things you will need to be aware of. These issues are addressed in detail later in this resource but, in brief, include:

*Understanding trauma, its effects and how it relates to substance use/misuse **(see section 1)**

*Screening and assessment tools **(see section 2)**

* Trauma Related Mental Health Disorders **(see section 3)**

*Transgenerational Trauma **(see section 4)**

* How to recognise guilt, shame and secrecy associated with the negative consequences of traumatic experiences. **(see section 5)**

* Foundations for safe trauma treatment **(see section 6)**

* A sample of interventions and tools **(see section 7)**

* The importance of self-care and avoiding vicarious trauma **(see section 8)**

We are keen to hear your comments, feedback and experiences with using this Guide/Resource and to do this please contact us through the website.

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*"No single therapeutic technique seems to work, so treatment is still very much a puzzle. The pieces fit together differently for every survivor." (**Scheinin, 1999**)*

SECTION 1

What is Post Traumatic Stress Disorder?

Trauma in Northern Ireland.

PTSD is one of the most prevalent disorders in Northern Ireland. with an estimated 61% of the population have experienced a traumatic event in their lifetime and an estimated 8.8% of the adult population meet the criteria for PTSD at some point in their life, with those events associated with the conflict being a major traumatic stressor for the population. On a gender note, females had a higher conditional risk of PTSD following exposure to traumatic events and in relation to the experience of traumatic events one study found that females were significantly more likely than males to meet the criteria for lifetime and 12-month PTSD.

It is estimated that 80% of the adult population experienced their first time traumatic event before they reached the age of 29 years. There is evidence to suggest that exposure to traumatic events in childhood and adolescence in particular can have a substantial psychological impact in later life (Thabet et al.2003) with consequences for those adults growing up as children throughout the troubles. Kessler and colleagues (2010) highlight the importance of childhood trauma in determining adult mental health outcomes. In their cross national study (including data from 21 countries) of the association of childhood adversities with adult psychopathology across 12 types of disorders across all countries, the research has shown that the figures for PTSD lay in the upper range of international estimates in Northern Ireland compared to other countries including South Africa, Israel and Lebanon.

Studies from the early days of the 'troubles' did not detect any marked evidence of adverse mental health consequences. It is only as time has passed that further studies began to pick up something of the distinctive mental health impact of the violence. One reason for this might be due to the effect of the cessation of violence creating a safer place for people to express their feelings and get their needs met. According to Tomlinson (2007) the conflict affected everything and the society as a whole has been "traumatised" with brutalisation being common and "resistance to change engrained and depression and anxiety widespread".

The Trauma, Alcohol and Drugs Comorbidity report (on our website) pointed out that interviewees had agreed that there was a great need for psycho-education both within the community; for family members and for individuals who were experiencing trauma and substance abuse. This was important in order to have more understanding of how it affected the individual experiencing the trauma, what issues they could expect to be dealing with in their family, and a sharing of coping mechanisms that families would find useful. This recommendation was quickly followed up with a Leaflet entitled,`Traumatic Stress, Alcohol and Drugs Information leaflet for Individuals & their Families' (available on website).

If the post-traumatic symptoms are not addressed then sufferers are in danger of descending into a spiral of disconnection with people, social isolation, loneliness, poor physical health, depression or other anxiety disorders and maladaptive coping mechanisms such as substance abuse. The use of alcohol, drugs, caffeine or nicotine in order to cope with their symptoms may. eventually lead to dependence on these substances. The most common coping strategy can be to use substances such as alcohol and prescribed drugs/medication to ease or numb the pain of the trauma and the associated symptoms. Research carried out by the Trauma Resource Centre (Belfast Health & Social Care Trust) found that "..the psychological impact of the 'troubles' continues to be realised, and despite the cessation of widely politically motivated attacks, the events experienced during the troubles still haunt the minds of many" (Dorahy et al, 2010).

Post-traumatic stress disorder (PTSD) was included in the American Psychiatric Associations Diagnostic and Statistical Manual of Psychiatric Disorders Third Edition (DSM III) in 1980. Around this time, PTSD was also included In the European International Classification of Diseases. PTSD and other trauma related mental health disorders are often unrecognised by practitioners/clinicians and other healthcare practitioners. Post-traumatic stress symptoms and substance use is a very common co-existing picture, and together can exacerbate other related symptoms such as anxiety and depression. Importantly there is evidence that suggests that the person suffering from PTSD will benefit from treatment regardless of the time elapsed since the traumatic event (Gillespie et al, 2002).

The physiology of trauma

The trauma response is designed for survival. It is everyone's automatic response to threat. Normally, once a threat is removed, or is no longer present, the trauma response abates. Thus ongoing problems after a traumatic event are a malfunction of the fight/flight/freeze trauma response. How this happens is very complex. Below is a brief, simplified account of the process.

When a person experiences a traumatic event a part of the brain called the amygdala flares. It is the protector part of the brain that tells us that DANGER is present, and is also part of the limbic system. This firing does a number of things to enable the person to most efficiently prepare to manage the danger: it shuts down cognitive processing power and shuts off the anterior cingulate gyrus, the time detector part of the brain that tells us if we are in real or imagined time, reduces the ability to feel pain and activates the multi-vagal nerve response preparing the body to fight or flee.

During the traumatic event memories may not be formed in the usual way because of the process described above. Cues and triggers for trauma responses can appear quite random because one main sense — sound, sight, smell, taste, or physical sensation — will be activated during the trauma experience. The other senses are also activated but go into the inaccessible or unconscious memory. In people who suffer from PTSD, the amygdala is triggered by false alarms and the trauma is reinforced. This also causes chronic overload in the sympathetic and parasympathetic (fight/flight) nervous systems which over time can lead to physiological changes and physical ill health.

Cumulative exposure to traumatic events has a powerful potentiating effect, for example, a person who has survived childhood sexual abuse, but as an adult is involved in a war conflict or natural disaster. The unresolved childhood trauma plus the disaster are too much to cope with; the sum of traumas is more than the effects of each individual trauma. This effect is known as trauma loading. Like a repetitive stress injury on a joint, brain circuitry wears out from the effects of stress hormones and changes in the structures and architecture of the brain occur. It will never go back to what it was but the effects can be managed and dampened down.

*"Northern Ireland does have a higher usage of these drugs (tranquillisers and sleeping pills) which has been attributed partly to the legacy of the `troubles'." (**S. Rainey, 2011**)*

Alcohol Misuse

In recent years we have learnt much more about co-existing conditions within the context of N.Ireland and the significant role of alcohol misuse.

What is Alcohol Misuse?

Alcoholism, alcohol dependence, alcohol misuse or alcohol addiction is characterised by two things:

- A person's life is centred around alcohol, and
- Alcohol plays a harmful role in that persons life (from Conor Farren, 'Overcoming Alcohol Misuse, A 28-Day Guide, 2011)

Alcohol MisUse Disorder: This the most prevalent Co-existing condition with post-traumatic stress disorder (Kessler 1995). At lower doses alcohol can act as a stimulant, may also lower anxiety and inhibit fear; therefore it is evident how this may, in the short-term assist the person suffering from PTSD cope with a number of physical symptoms such as hyperarousal and provides ease for some social situations. However this relief is only temporary and the use of substances to reduce these symptoms is ultimately harmful to the individual, their relationships, to be productive in work and life in general. At higher doses alcohol acts as a depressant and alcohol misuse or dependence may also be responsible for causing interpersonal problems or indeed exacerbating them.

Drug Misuse

Trauma survivors may self-medicate using stimulant or other drugs to maintain alertness to try to block the distress of intrusive thoughts and traumatic memories. The presence of additional disorders indicates a more complex clinical presentation. This will then necessitate the identification of several targets for both assessment and treatment according to the literature. The co-existence of post-traumatic stress disorder and substance abuse is described in literature as a 'downward spiral' where trauma symptoms are common triggers of substance use, which in turn can heighten post-traumatic symptoms (Najavits, 1997).

Literature substantiates the idea that co-existence is a complex problem and that some individuals may 'present' with substance dependency or misuse problems or they may 'present' with symptoms relating to PTSD. Traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition and memory (Herman, 2001) and therefore it should not be unexpected that people 'present' in varying states of crisis and emotional turmoil.

Traditionally, service users with co-existing conditions were/are sent to one treatment setting or another to address their problems sequentially. They have been advised to 'solve" their addiction problems before entering mental health treatment or stabilise their mental health problems before entering addiction treatment. However much of the research and experience would conclude that this has not been effective since each condition tends to exacerbate the other. A more holistic approach is needed.

Reactions to Trauma

A traumatic event involves a single experience, or an enduring or repeating event, that can overwhelm a person's ability to cope or work through the ideas and emotions involved with that experience. There is frequently a violation of the person's familiar ideas about the world and of their human rights, putting the person in a state of extreme confusion and insecurity.

Most people experience one or more traumatic events in their lifetime but only a proportion of people will go on to suffer PTSD.

"69% of adults in normal populations will experience a serious traumatic event at some stage in their lifetime" (Norris, 2005).

People are unique and everyone responds differently to exposure to trauma. Many have strong emotional or physical reactions after the traumatic event, affecting how they think or behave. These are natural reactions to abnormal events. Mostly these reactions start soon after an event but, in some cases, the feelings do not start until months or years later.

Trauma Internationally

A wide variety of events can be traumatic. They may be man-made" (e.g. war, rape, torture, child abuse, road accidents) or caused by a natural event (e.g. earthquakes, floods) and are either intentional or unintentional. Effects can be delayed by weeks, years or even decades. Psychological trauma can lead to serious long-term negative consequences that may be overlooked, even by experienced mental health professionals. If a person was substance affected at the time of the trauma, they will be at greater risk of developing trauma related mental health disorders because memory storage and retrieval will be compromised. Substance use interferes with a person's ability to manage a potentially traumatic event (PTE).

Categories of trauma

Trauma can fall into any of four descriptive categories:

- "Human-caused" trauma where acts are intentional (e.g. crime)
- "Human-caused" trauma where acts are accidental (e.g. road traffic accidents)
- "Nature-related" trauma
- "Nature-related" trauma complicated by human actions.

Human-caused or complicated traumatic events are well known to have greater potential for traumatisation. Person-implicated events that are by their nature horrific, prolonged, repeated, deliberate and/or malevolent have the greatest capacity to negatively affect people.

Trauma risk level

Some people are at greater risk than others of negative psychological and functional outcomes following exposure to Post Traumatic Events (PTEs). Known "high-risk" groups include:

- Women
- Young people
- Elderly people
- People with chronic illnesses and diseases, especially pain and mental health conditions
- People who are economically, materially or socially disadvantaged
- People who experience cumulative traumatic events

Individual response styles

It is well known that a person's individual response style can help or hinder them in dealing with PTEs. Some people may be exposed to traumatic events and experience no ill effects or may actually grow from the experience, while others respond in ways that hinder their recovery.

For example, the following response styles are likely to hinder recovery:

- Highly anxious pre-trauma response style. The person tends to avoid situations that may be anxiety provoking, especially through the use of substances or engaging in unhelpful behaviours such as problem gambling
- Rigid response style. The person is less likely to recover speedily or easily as they find change more difficult.
- Cynical or self-critical response style. The person is unable to respond to advice or offers of assistance with an open mind and this is unlikely to aid their recovery process.
- Highly angry post-trauma response style. The person is likely to find that this interferes with their progress. Anger is known to be a powerful predictor of recovery, the greater the anger, the more difficult and delayed the process of post-trauma recovery can be.

Symptoms

Trauma can affect people in many ways. Individuals may exhibit a range of symptoms from all or some of these problem areas. People's experiences of post-trauma distress are highly individual, but this list will give you some idea of what you might look for in a client who has experienced trauma.

- Thought/cognitive problems. Reliving the experience, nightmares. hypervigilance, poor problem-solving ability, loss of orientation, memory, concentration or attention problems, flashbacks, homicidal or suicidal intrusive thoughts or images, poor decision making, suspiciousness, dissociation, blaming self or others.
- Emotional/feeling problems. Anxiety, social isolation, anger or emotional numbing, sudden mood shifts, irritability, grief, depression, guilt, shame, denial, feeling overwhelmed or fear.
- Behavioural problems. Withdrawal, heightened startle reactions, increased or decreased appetite, avoiding reminders of the traumatic event, acting out, agitated behaviour, substance use, homicidal or suicidal tendencies.
- Interpersonal responses. Difficulty in forming intimate relationships, sexual intimacy problems and sexual performance issues, change in usual communication patterns, revictimisation or suspiciousness.
- Physical responses. Shock, dizziness, headaches, chest pain, difficulty breathing, muscle tremors, fatigue, elevated blood pressure, profuse sweating, vomiting/nausea, teeth grinding, somatic disturbance, extra sensitivity of the senses (sights, sounds, smells, touches and tastes), that may be associated with the traumatic event.

Many people experience PTEs and do not develop any significant lasting post-trauma effects. When the post-traumatic reaction is not resolved and its impacts worked through, for whatever reason, it may become problematic. If such symptoms continue and affect a person's well-being, it is possible they may be suffering from the trauma and PTSD.

SECTION 2

Screening For Trauma

Screening is a component of an assessment. It is only a brief method of determining whether a particular condition is present. A positive screen should trigger a detailed assessment that will confirm whether the co-existing condition is indeed present and it should be done at or near their first point of contact with the treating service. In turn assessment of Trauma. Alcohol and/or Drugs will inform the integrated treatment planning of all redetected conditions.

INTEGRATED TREATEMENT: The development of the most effective treatment responses to the needs of people with co-existing conditions rests on providing treatment of both a service users substance misuse and trauma. Integrated treatment also occurs when clinicians/practitioners from separate agencies/organisations collaborate to develop a singe treatment plan addressing all the conditions and the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the service user.

It is a reality of most service systems that the various clinicians/practitioners, agencies and sectors have differing capabilities to provide 'in-house' and 'one-stop-shop' integrated treatment of co-existing conditions. Clients may not mention that they have experienced trauma when they first present for treatment. So it is important to ensure all clients are screened and assessed for past history of such events. This will increase the probability that effective treatment will be implemented. If trauma is overlooked, this may negatively impact on treatment effectiveness

However with the encouragement of using this Guide/Resource and through the Forum's networking process, it is hoped that this will assist services to be actively developing their capacity to routinely develop integrated planning with services from other sectors.

In seeking to understand the origins of presenting problems, the screening practitioner could routinely enquire for Trauma about any experience of stressful or traumatic events, both recently or in the past, using a range of tools to get a full picture of the situation. Depending on your workplace, these may include tools that assess for substance use problems, PTSD, anger, anxiety, depression, gambling, quality of life and sleep.

Assessment & Screening for trauma is an essential part of your overall work. Asking if trauma has occured:

- Opens the issue to the client for processing further down the track
- Gives meaningful context for them to understand their feelings, thoughts and behaviours
- Empowers them to search for and find the kind of help that best suits them.

Note: Asking if a traumatic event has occurred and the impacts of this is not the same as opening up and exploring the trauma, which should only be done by practitioners/clinicians with trauma training.

Asking about trauma safely.

When a client presents for treatment, they may worry that you are going to ask them about the trauma before they have the necessary skills to help them manage going over it again. Telling their story from memory is like re-living the experience as though it is actually happening. It is important not to go into the trauma story too quickly; the client needs to be able to think and feel at the same time in order to be able to process the experience properly. It is best practice, if assessment happens prior to allocation in your service that trauma assessment is done once a person has been allocated to a worker, and it is done as close to the first session as possible, but not during the initial meeting.

Clinicians also often believe that asking about any trauma may open a 'can of worms'. However, not asking can add to the message the client may have already perceived about secrecy—either about the traumatic event or their reaction to this. Whereas it has been pointed out that in Northern Ireland , trauma has been a socially normalised experience you risk colluding with the prevailing normalisation. It is crucial that you do not reinforce this idea. Remember that trauma survivors have often held onto their experience for a very long time; just asking will not make them break down. In most cases, they will have the resources to continue to hold on to the memories until an appropriate time in treatment to address it more fully, safely and effectively.

Note: It is crucial that you understand and clearly explain to the client the difference between asking about trauma for screening and asking them to 'unpack' which is part of a more advanced treatment.
These issues are explained in more detail in section 6.

"It is not unusual for individuals experiencing trauma to become involved in self-destructive behaviours such as substance misuse or self harm as a way to cope and manage unbearable distress" ***Dass-Brailsford & Myrick, 2010***

Some tips for asking about trauma safely:

- Make the client feel comfortable.
- Establish rapport and create a supportive atmosphere where the client feels safe to discuss the trauma
- When asking about trauma, empower the client by giving them options; for example, to answer now or at another time, i.e. they don't need to answer if they don't want
- It is usually not appropriate to ask about trauma during an initial meeting; first a relationship should be established.
- Remember this is a sensitive issue and needs to be approached sympathetically.
- Do not display negative emotion or value judgements at disclosed trauma and abuse.
- Be very clear, unambiguous and use straightforward language to avoid confusion and encourage straightforward responses. For example, when asking about: physical abuse, ask if person has ever been beaten, kicked, punched, or choked.
- Sexual abuse, ask about experiences of being touched sexually against their will or whether anyone has ever forced them to have sex when they did not want to.
- Asking if a person has experienced a traumatic event is not the same as going deeply into it. Closed questions, where the client responds with a 'Yes' or 'No' response to whether they have had a particular experience, helps contain the screening process.
- Before you start screening, explain to the client what will happen and why it is necessary. Ask permission to go ahead.
- Check with the client periodically if it's ok to continue, especially if there are signs of distress. If in doubt ask the client.
- If you are concerned at any point about a client's immediate well-being, conduct a risk assessment and take the necessary action, letting the client know at all times what you are doing and why.
- Know your limits. It is not appropriate to try to go deeply into the memories without proper training and client preparation. Use your clinical judgement as to whether you and the client are in a position to discuss the trauma issues safely. Some clients will have processed the traumatic event effectively and be able to talk about it safely without intervention or due to previous work they have done.
- Attend extra training to help you feel more confident and competent when asking about trauma.

Note that some level of stress is important to function and one of the effects of trauma might be numbing. Assessment should look out for this as well as distress. Numbing is less likely to show up in a screening tool, yet it may be an important Indicator.

In your health service or community there are likely to be a number of public domain screening tools that directly address trauma. Mental health tools that screen for emotional distress, can indirectly detect symptoms, but are not usually diagnosis-specific for post trauma related issues. It is therefore important that further assessment be undertaken as required. If a client scores positively on any mental health screen for emotional distress or high prevalence disorders, this may indicate that further assessment for the effects of trauma is required. Screens are available for PTSD but a trauma-focused comprehensive assessment carried out by a practitioner/clinician with expertise in the area may be required. This may be from a specialist organisation or someone within the workplace who has been trained specifically.

Further information on PTSD standards and guidance can be found on the website of the National Institute for Health & Care Excellence.

Here are a few examples of screening tools for PTSD you may find useful and the recommended assessment tools for trauma are the Impact of Events Scale and the Post Traumatic Cognitions Inventory. You may know of others so please let us know and email address is at the end of this document and on the website.

Impact of event scale - revised

your name: *today's date:*

on _____ you experienced _____ (date) (life event) below is a list of difficulties people sometimes have after stressful life events. please read each item and then indicate how distressing each difficulty has been for you *during the past 7 days or other agreed time:*		*how distressing?*				
		not at all 0	*a little bit* 1	*moder -ately* 2	*quite a bit* 3	*extre -mely* 4
a.	any reminder brought back feelings about it					
b.	I had trouble staying asleep					
c.	other things kept making me think about it					
d.	I felt irritable and angry					
e.	I avoided letting myself get upset when I thought about it or was reminded of it					
f.	I thought about it when I didn't mean to					
g.	I felt as if it hadn't happened or it wasn't real					
h.	I stayed away from reminders about it					
i.	pictures about it popped into my mind					
j.	I was jumpy and easily startled					
k.	I tried not to think about it					
l.	I was aware that I still had a lot of feelings about it, but I didn't deal with them					
m.	my feelings about it were kind of numb					
n.	I found myself acting or feeling like I was back at that time					
o.	I had trouble falling asleep					
p.	I had waves of strong feelings about it					
q.	I tried to remove it from my memory					
r.	I had trouble concentrating					
s.	reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea. or a pounding heart					
t.	I had dreams about it					
u.	I felt watchful and on-guard					
v.	I tried not to talk about it					

avoidance subscale (total of e, g, h, k, l, m, q, v divided by 8) =

intrusion subscale (total of a, b, c, f, i, n, p, t divided by 8) =

hyperarousal subscale (total of d, j, o, r, s, u divided by 6) =

Weiss,D.S. & Marmar,C.R. *The impact of event scale-revised.* in Wilson,J.P. & Kean,T.M. (eds.) *Assessing psychcological trauma and PTSD: a practitioner's handbook (ch 15).* N.Y: Guildford, 1995.

Posttraumatic cognitions inventory (pcti)

your name: *today's date:*

We are interested in the kind of thoughts which you may have had after a traumatic experience. Below are a number of statements that may or may not be representative of your thinking. Please read each statement carefully and tell us how much you AGREE or DISAGREE with each by putting the appropriate number between 1 & 7 in the box to the right of the statement. People react to traumatic events in many different ways. There are no right or wrong answers to these statements.

1	*2*	*3*	*4*	*5*	*6*	*7*
totally disagree	*disagree very much*	*disagree slightly*	*neutral*	*agree slightly*	*agree very much*	*totally agree*

1.	the event happened because of the way I acted	
2.	I can't trust that I will do the right thing	
3.	I am a weak person	
4.	I will not be able to control my anger and will do something terrible	
5.	I can't deal with even the slightest upset	
6.	I used to be a happy person but now I am always miserable.	
7.	people can't be trusted	
8.	I have to be on guard all the time	
9.	I feel dead inside	
10.	you can never know who will harm you	
11.	I have to be especially careful because you never know what can happen next	
12.	I am inadequate	
13.	if I think about the event, I will not be able to handle it	
14.	the event happened to me because of the sort of person I am	
15.	my reactions since the event mean that I am going crazy	
16.	I will never be able to feel normal emotions again	
17.	the world is a dangerous place	
18.	somebody else would have stopped the event from happening	
19.	I have permanently changed for the worse	
20.	I feel like an object, not like a person	
21.	somebody else would not have gotten into this situation	
22.	I can't rely on other people	
23.	I feel isolated and set apart from others	
24.	I have no future	
25.	I can't stop bad things from happening to me	
26.	people are not what they seem	
27.	my life has been destroyed by the trauma	
28.	there is something wrong with me as a person	
29.	my reactions since the event show that I am a lousy coper	
30.	there is something about me that made the event happen	
31.	I feel like I don't know myself anymore	
32.	I can't rely on myself	
33.	nothing good can happen to me anymore	

Note, the original version of this inventory contained a further three questions, but the authors described them as "experimental" and did not include scores for these questions in the total score.

total score =

The total score is simply the sum of the individual scores for the 33 statements. In Foa et al's original paper (see below), the median score (with standard deviation) for non-traumatized subjects was 45.5 (34.8), for traumatized subjects without PTSD 49.0 (23.6) and for traumatized subjects with PTSD the median score was 133.0 (44.2) – see table below.

The inventory also yields three subscales – negative cognitions about the self (statements 2, 3, 4, 5, 6, 9, 12, 14, 16, 17, 20, 21, 24, 25, 26, 28, 29, 30, 33, 35 & 36), negative cognitions about the world (statements 7, 8, 10, 11, 18, 23 & 27) and self-blame (1, 15, 19, 22 & 31). To allow for the different numbers of statements making up each subscale, the scores are calculated by taking the total for the subscale and dividing it by the number of statements involved – giving an average score per statement for each subscale.

negative cognitions about self score (total/21) =

negative cognitions about world score (total/7) =

self-blame (total/5) =

	no trauma		*trauma but no ptsd*		*trauma with ptsd*	
	median	*sd*	*median*	*sd*	*median*	*sd*
neg self	*1.08*	*0.76*	*1.05*	*0.63*	*3.60*	*1.48*
neg world	*2.07*	*1.43*	*2.43*	*1.42*	*5.00*	*1.25*
self-blame	*1.00*	*1.45*	*1.00*	*1.02*	*3.20*	*1.74*
total	*45.50*	*34.76*	*49.00*	*23.52*	*133.00*	*44.17*

Foa, E. B., A. Ehlers, et al. (1999). *"The posttraumatic cognitions inventory (PTCI): Development and validation."* Psychological Assessment **11**(3): 303-314. (Free full text available from http://www.octc.co.uk/files/pdfs/PTCI.pdf) This article describes the development and validation of a new measure of trauma-related thoughts and beliefs, the Posttraumatic Cognitions Inventory (PTCI), whose items were derived from clinical observations and current theories of post-trauma psychopathology. The PTCI was administered to 601 volunteers, 392 of whom had experienced a traumatic event and 170 of whom had moderate to severe posttraumatic stress disorder (PTSD). Principal-components analysis yielded 3 factors: Negative Cognitions About Self, Negative Cognitions About the World, and Self-Blame. The 3 factors showed excellent internal consistency and good test-retest reliability; correlated moderately to strongly with measures of PTSD severity, depression, and general anxiety; and discriminated well between traumatized individuals with and without PTSD. The PTCI compared favorably with other measures of trauma-related cognitions, especially in its superior ability to discriminate between traumatized individuals with and without PTSD.

SECTION 3

Trauma-Related Mental Health Disorders

A number of mental health disorders are commonly related to trauma. Disorders may occur discretely or together to form a syndrome of co-existence. Substance use disorders (SUDs) very commonly co-occur with PTSD.

Anxiety disorders can appear separately post-trauma or in conjunction with other mental health disorders.
They include the following:

Panic attacks

Described as a sudden onset of intense apprehension, fearfulness or terror often with feelings of impending doom. May also include physical symptoms, such as palpitations and breathing difficulties, or a fear of going crazy.

Phobias

May be specific to a particular place or thing, for example, social phobia or agoraphobia. All phobias have in common the avoidance of the situation or thing that causes fear.

Obsessive-compulsive disorder (OCD).

Characterised by obsessive thoughts that cause anxiety or distress and compulsive behaviours designed to neutralise the stress.

General worry or obsession: People who have been traumatised can develop general worrying (which may be classified as generalised anxiety disorder, or GAD, if it lasts for more than six months) or may become obsessively neat and orderly. Acute stress disorder (ASO) and PTSD, are the anxiety disorders that are directly linked with trauma experience and are outlined in more detail below.

*One definition of Trauma: "An event outside the usual realm of human experience that is markedly distressing – evoking reactions of intense fear, helplessness, terror" (**Z Solomon, 1996**)*

Acute stress disorder

It is characterised by the development of severe anxiety, dissociative and other symptoms that occur within one month of exposure to a traumatic event. ASD can be diagnosed between two days and four weeks after trauma. People with ASD have a decrease in emotional responsiveness, often finding it difficult or impossible to experience pleasure in previously enjoyable activities and frequently feel guilty about pursuing usual life tasks.

A person with ASD may:

- Experience difficulty concentrating
- Feel detached from their bodies
- Experience the world as unreal or dreamlike
- Have increasing difficulty recalling specific details of the traumatic event
- Go to significant lengths to avoid stimuli that arouse recollections of the trauma (e.g. thoughts, feelings, conversations, activities, places or people)
- Have significant symptoms of anxiety or increased arousal (e.g. difficulty sleeping, irritability, poor concentration, hypervigilance, an exaggerated startle response and restlessness)

Specific Symptoms of PTSD

PTSD is the most widely known trauma-related disorder in which an individual is exposed to an extremely traumatic event to which they have reacted with intense fear, horror or helplessness. It involves experiencing, witnessing or being confronted by an event where there is actual or threatened death or serious injury or threat to one's own or someone else's physical integrity which results in experiencing a number of symptoms, including a significant level of distress and/or social impairment.

Symptoms include:

Reliving. Symptoms include:

- reliving of experiences (e.g. flashbacks), where the event seems to be recurring
- repeated upsetting memories of the event
- repeated nightmares of the event
- uncomfortable physical and psychological reactions to reminders of the event

Avoidance. Symptoms include:

- emotional numbing - feeling as though you don't care about anything
- feeling detached
- being unable to remember important aspects of the trauma
- having a lack of interest in normal activities
- showing their moods less readily
- avoiding places people or thoughts that remind them of the event
- feeling like there is no future

Arousal. Symptoms include:

- difficulty concentrating
- startling easily
- having an exaggerated response to things that startle them
- feeling more aware of everything in search of potential dangers (hypervigilance)
- feeling irritable or having outbursts of anger
- having trouble falling or staying asleep

Bipolar Affective Disorder

An important differential diagnosis for PTSD is that of bipolar affective disorder (especially type 1,with its cycling from manic to depressive symptoms) can look much like PTSD (and vice versa) in certain presentations. Each disorder requires different specialist treatment, again highlighting the need for thorough assessment.

Depression

It is also common for people who experience a traumatic event to become depressed. Signs of depression include low mood, loss of pleasure, low self- esteem, and feelings of sadness, hopelessness, and worthlessness - all of which impact on daily life. Other symptoms include changes in sleep patterns (too much or too little), changes in weight, loss of energy, problems thinking clearly or concentrating and possible suicidal ideation.

Dissociative Disorders

The essential feature of dissociative disorders is a disruption in the usually integrated functions of consciousness, memory, identity and perception. Dissociation is a mental process in which a person disconnects from their thoughts, feelings, memories or sense of identity. Dissociation can be a significant feature of a post-traumatic condition. An underlying cause of dissociate disorders is chronic trauma in childhood. There is evidence to suggest that the severity of the dissociative disorder in adulthood is directly related to the severity of the childhood trauma. However, traumatic events that occur during adulthood can also cause dissociative disorders. Such events may include war, torture or going through a natural disaster.

Somatoform disorders

The common features of somatoform disorders are the presence of physical symptoms that cannot be explained by a diagnosed medical condition or the effects of a substance or another mental disorder. The symptoms are not under a persons voluntary control and may arise as a response to trauma. Some examples of somatoform disorders include psychogenic paralysis (losing use of a limb or half of the body), psychogenic sensory symptoms (numbness), psychogenic seizures, psychogenic coma, psychogenic blindness and hysterical aphonia (loss of ability to produce sounds). The term psychogenic (previously known as pseudo') simply means that the symptom is psychological in origin.

Conversion disorders

Conversion disorders are a form of somatisation in which people convert their emotional problems into physical symptoms. The immediate cause of conversion disorders is a stressful event or situation that leads the person to develop bodily symptoms as a symbolic expression of a psychological conflict or problem. Physical, emotional or sexual abuse in adults and children can contribute. Conversion disorders may also develop in adults as a long-delayed after-effect of childhood abuse. Conversion reaction is sometimes considered to be a dissociative phenomenon.

Complex Tauma and DESNOS

Complex trauma or disorder of extreme stress not otherwise specified (DESNOS) refers to a condition resulting from multiple exposures to one or more PTEs. As its name implies, complex trauma involves complex interactions between multiple bio-psycho-social systems. When the human organism is repeatedly exposed to traumatic stress, disruptions can occur in brain functions and structures, endocrinological function, immunological function and central and autonomic nervous system arousal. These biological disruptions interact with psychological, emotional, spiritual and cognitive processes and can result in a variety of disturbances that go beyond the re-experiencing, avoidance/numbing and arousal symptoms that characterise PTSD.

In addition to problems with accurately perceiving, evaluating and responding to incoming stimuli, other symptoms of complex trauma may include problems with memory, identity and emotional regulation. The range of situations that could cause DESNOS may involve something extreme (like torture or combat) or more common experiences such as discrimination, harassment or abuse.

Psychosis

There are three main alternative relationships to be considered when looking at the relationship between trauma and psychosis:

- Can psychosis cause PTSD?
- Can trauma cause psychosis?
- Could psychosis and PTSD both be part of a spectrum of responses to a traumatic event?

There is evidence that all of these relationships exist. When working with someone who experiences psychotic phenomenon, it is important to assess for and work with related trauma experiences. Practitioners/Clinicians should not dismiss delusional content or hallucinations, as they may hold metaphorical or real information about the traumatic experience. It is also important to be aware of safety factors for the client, giving them strategies and support to prepare for addressing the trauma such as grounding and learning to create a safe place in the imagination.

When working In the AOD sector, it is important to work within the limits of your role to ensure that acute psychosis is stabilised. This usually means working with a mental health clinician and a GP or other prescriber as medication may form part of treatment. Not all mental health clinicians are skilled at helping clients to work through trauma and its impact. A specialist intervention may need to be sought for this phase of treatment from someone who has training and experience in trauma therapy.

Note that some grief symptoms may include auditory or visual hallucinations. These usually alleviate within a few weeks. If they don't, further assessment may be required.

Personality Disorder

Surveys of Personality disorder only started in the 1990's. A World Health Organisation screening survey across 13 countries reported in 2009 a prevalence of around 6% for Personality Disorder with this rate being raised in co-occurring mental disorders.

Description

A Personality disorder is; "Types of enduring behaviours associated with significant distress or disability, which appear to deviate from social expectations particularly in relating to others." (DSM 5)

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) 2013, list ten personality disorders in three clusters.

Cluster A (odd or eccentric disorder)

- Paranoid Personality Disorder: characterised by irrational suspicions and mistrust of others.
- Schizoid Personality Disorder: lack of interest in social relationships, anhedonia, introspection.
- Schizotypal Personality Disorder: odd behaviour or thinking.

Cluster B (dramatic, emotional or erratic disorders)

- Antisocial Personality Disorder: pervasive disregard for the law and the rights of others.
- Borderline Personality Disorder: extreme black and white thinking, instability in relationships, self image, identity, self harm, impulsivity, three times more likely to be found in females.
- Histrionic Personality Disorder: pervasive attention seeking, inappropriately seductive behaviour and shallow and exaggerated emotions.
- Narcissistic Personality Disorder: pervasive pattern of grandiosity, need for admiration, and a lack of empathy.

Cluster C (anxious or fearful disorder)

- Avoidant Personality disorder: social inhibition, inadequacy, extreme sensitivity to negative interaction and avoidance of social interaction.
- Dependant Personality Disorder: pervasive psychological dependence on others.
- Obsessive Compulsive Personality disorder: (not the same as OCD) characterised by rigid conformity to rules, oral codes and excessive orderliness without insight into such behaviour.

Others:

- Personality Disorder due to medical conditions.
- Personality Disorder indicative of: Depressive, Passive Aggressive, Sadistic and Self Defeating.
- Non Specific Personality Disorder

DIAGNOSIS

The following need to be present in the individual:

- An enduring pattern of psychological experience and behaviour that differs from cultural expectations as shown in two or more of; cognition, affect, interpersonal functioning or impulse control.
- The patterns must be inflexible across a wide rang of situations and lead to clinically significant distress.
- The pattern must be stable and long lasting and have started at least in early adulthood.
- The pattern must not be better accounted for by another mental health diagnosis or by substance misuse.

Why Higher Rates?

Drug and alcohol misuse very commonly co-occurs with PTSD. The presence of co-existing PTSD has been associated with poorer SUD outcomes. The relationship between trauma and SUDs is strongly established. Yet, despite their greater rates of psychiatric comorbidity, people with PTSD generally do not receive treatment for these problems.

The following theories attempt to explain why people with PTSD have higher rates of alcohol and drug use. Research supports all of these theories; one explanation may be more applicable than another, depending on a person's family history, age, gender or whether or not they have another disorder such as depression.

1 High-risk theory

The high-risk theory states that drug and alcohol problems occur before PTSD develops. Proponents of this model believe that the use of alcohol and other drugs puts people at greater risk of experiencing traumatic events, and therefore, at greater risk of developing PTSD.

2 Self-medication theory

The self-medication theory states that people with PTSD use substances as a way of reducing the distress tied to particular PTSD symptoms. For example, alcohol (a depressant) may be used to reduce extreme hyperarousal symptoms.

3 Susceptibility theory

The susceptibility theory suggests that there is something about alcohol and other drug use that may increase a person's risk of developing PTSD symptoms after experiencing a traumatic event.

4 Shared-vulnerability theory

This theory states that some people may have a genetic vulnerability that increases the likelihood that they will develop both PTSD and substance abuse problems following a traumatic event.

SECTION 4

Other Cohorts Affected By Trauma

TRANSGENERATIONAL TRAUMA - N.IRELAND AND INTERNATIONALLY

The second and third generation experience and exhibit the same symptoms of trauma as the victim/survivor themselves. The emotional cost of living with a parent suffering from PTSD can lead to negative psychological consequences much later in life as these individuals develop more, behavioural and emotional problems than those who did not have parents with PTSD (Jacobsen, Sweeny & Racusin 1993).

Those who are experiencing trans-generational issues often do not recognise that the 'troubles' can be affecting their mental health and possibly co-existing conditions in the present.

TRANSGENERATIONAL TRAUMA

Children who live with a traumatised parent are influenced by the PTSD symptoms that the parent displays at home. The emotional instability that comes with PTSD becomes embedded in the child. Trauma can be passed from parents to their children (intergenerational transmission of trauma) and the children can start displaying the symptoms of PTSD as well (e.g. start having nightmares about the parent's trauma, anxiety, difficulty concentrating, emotional numbness etc). The research of secondary traumatisation began with the study of children of holocaust survivors and with the years developed to other traumata. The most recent research suggest that PTSD can also be transferred genetically and not solely due to learned or psychological implications. Children of parents with PTSD have higher risk of emotional, behavioural, academic and interpersonal problems (Lev-Weisel, 2007). The children exhibits more depression, anxiety, aggressiveness, act out, poor attitude towards others, hyperactivity, practice self -destructive behaviour and have more difficulties forming and maintaining positive relationships.

Feeling disappointed, unsupported, unloved, rejected by a parent who is emotionally numb, detached, psychologically absence and/or avoids places/people/activities due to high anxiety may cause low self-esteem, intensifies anxiety and depression and also reduces the child's ability to relate to others (Ruscio. Weathers, King. & King. 2002). Irritability, low frustration tolerance and aggressive behavior of the parent can lead the child to question his own behaviour and in extreme cases of violence even own self-worth. It naturally also increases the probability of the child becoming aggressive himself and developing academic and interpersonal problems in school (Harkness,1993). Some children realise that the parent is not able to function well and they take over the parenting role. The child essentially takes care of the parent and tries to stabilise the situation at home by taking over all the responsibilities. The burden of the psychological as well as the functional responsibility are clearly beyond the emotional, behavioural and cognitive capacities of the child and thereby causes distress, stress, as well as loss of innocence and carefree living, which every child should be able and has the right to experience.

Four ways in which the PTSD symptoms can be transmitted.

Silence

Silence could originate from the fear of creating discomfort or triggering negative distressing reactions in the survivor. Some may believe that talking about it could make the symptoms worse. When the topic of the trauma and the symptoms becomes a taboo in the family to the extent that no one talks about it at all, discussions about thoughts, emotions and events are avoided. The child does not get any explanation to the parents' symptoms and therefore the child's anxiety increases. Children may also worry about their parent's ability to take care of them. The child worries about the parent's well being and starts developing his/her own ideas about why the symptoms are present. The child may create an imaginary and horrifying story in his mind of what happened to the parent. A drastic and horrendous story might be woven that could possibly be worse than the actual trauma. By creating imaginary details in one's mind, the child begins to experience emotions and thoughts that relate to that imagined story.

Over-discloser

On the opposite of the continuum lays the over-discloser parent. A parent that tells every specific and explicit details of the trauma, especially when not age appropriate, can cause the child to develop high anxiety, distress, depression and PTSD symptoms in response to the detailed images that were given. Children who experienced extreme fear, horror and helplessness due to the

detailed narrative are at higher risk of developing PTSD (Yehuda et al.1998). Some parents may think that that a detailed story will help prepare the child to the dangers hidden in the world and by knowing every details, the child will know what to look in order to protect himself. The family's norms and beliefs are passed down from one generation to the next. As a result the child also develops a belief that danger is creeping around the corner, no one can be trusted, people are evil and that life is uncontrollable and unpredictable. The core beliefs of a child shatter completely.

Imitation

Children also learn from observing and imitating their parents. Children of survivors may therefore take over some of the behaviours and emotional states of their PTSD parents (Kellermann, 2001). Children who are continuously exposed to PTSD reactions (e.g. flashbacks) may find themselves taking part in the re-enactment of the parent's trauma. The parent re-experiences the trauma as if it is reoccurring in the present and has difficulty distinguishing between the past and the present. A child present at the time might find himself being pulled into that re-enactment. Due to this re-enactment the child could start thinking, feeling and behaving as if it happened to him/her too.

Identification

Identification is the last method of trauma transference. The over-identified child begins to share symptoms as a way of connecting or understanding the parent with PTSD better.

WHAT CAN BE DONE

Children who do not understand the symptoms may blame themselves for the parent's behaviour thus it is important to explain the symptoms to the child in her/his cognitive and maturity level. It is important for the child to understand that the symptoms have nothing to do with her/him but with a trauma that the parent has endured. If you don't really know how or what to say, it might be useful to ask for the assistance from a Child Psychologist and/or Family Therapist. It is important to be alert and observe the children and their emotional, psychological and behavioural reactions. Children will have enough difficulties adjusting to the new situation without taking on any adults' responsibilities or becoming an emotional support resource. Children are emotionally and cognitively incapable of handling that burden, distress and stress. Family therapy may also benefit the family of a PTSD Service User and assist the family members better understand and cope with the PTSD.

Adolescence

Bearing this in mind Treatment approaches for adolescents must be tailored to the profound neuro-chemical, physical, cognitive, emotional and social changes that take place during adolescent development and to the heightened influence of family and peers relative to adult service users. Because early initiation of substance use is related so strongly to the risk of addiction, interventions for young people demonstrating early signs of risky substance use and treatment for addiction. However, treatment approaches with a strong evidence base in adult populations are not necessarily applicable to the treatment needs of adolescents with addiction. Thus treatment programmes for adolescents should be developed appropriately and family orientated.

GLBT

The gay, lesbian, bisexual, transgender (GLBT), population has it is believed higher rates of AOD use, compared to the general population. GLBT people are also at greater risk of discrimination and stigma, as well as public insults, explicit threats and physical assault. All of these can lead to social isolation and family or peer rejection. Although there is little specific research into co-esisting trauma and AOD issues in this cohort, there is a high prevalence of mood, anxiety and substance use disorders. Given this, it is reasonable to predict they would be at high risk of developing trauma-related problems such as ASD, PTSD and DESNOS.

"There's a certain kind of loss... The fact of not knowing your father; it's like a void that can never be filled no matter what happens...There's uncles that try to be decent to you, and there's different men in your lifetime that try to be decent...but the loss of your father and not to know him, for him not to take you to football matches and for him not to take you fishing and for him to walk down the street with you. It's just a terrible, terrible loss".

(The Cost of the Troubles Study: Do You See What I See? 1998)

SECTION 5

Trauma-Related Emotional States

Guilt

'Survivor guilt' is the term given to the feelings people who have survived a traumatic event may experience. People may become confused about why they were spared when others perished. They may feel the burden of survival and think that they should have been able to do something more to prevent the "bad thing" from happening. These feelings are not always logical; often the memory of the event can be altered by the trauma. An important part of the healing process may be to review the event (sometimes with information also coming from family, friends or others who were present when the event occurred). By doing this, the person can stop blaming themself for what went wrong when they couldn't have been responsible and forgive themself for any mistakes that may have occurred. It is human to make mistakes, particularly in high-stress situations. Survivors may punish themselves consciously or unconsciously, so it is important for the trauma survivor to find a way to acknowledge feelings of guilt and forgive themselves. Feeling guilt may also be a protective mechanism to avoid other more distressing emotions such as helplessness.

As we have seen, people's responses to trauma vary but there are some common emotional responses that you need to be aware of when helping your clients with trauma issues.

Grief and loss

Loss can be part of the experience of trauma: loss of innocence, trust, safety, roles, self, a loved one - and grief is the natural response to loss. A person may seek to avoid grief because it is too painful. Depression can be the result. To come to terms with grief, trauma survivors must 'process' it by feeling the loss and reflecting on its meaning. This can be extremely difficult, particularly if they have been avoiding it for many years. Feelings associated with grief and loss (such as pessimism, sadness and hopelessness) may be masked by substance use. A person may behave in a number of other ways to protect himself or herself, such as compulsive caregiving, withdrawal and isolation, fierce self-sufficiency or guardedness and suspiciousness

As we have seen, people's responses to trauma vary but there are some common emotional responses that you need to be aware of when helping service users with trauma issues.

Shame

When we feel guilt, we believe that it is our actions that were wrong. Shame involves feeling that the self - who we are - is wrong or bad. The physiological component of shame is a shrinking action to hide or disappear from self and others. Shame is not a product of a specific situation, but arises from a person's interpretation of an event. When people believe that they should be coping better following a traumatic event, feelings of shame often emerge. A way of managing shame is to withdraw from others; substance use may be a way of withdrawing. Becoming angry is another effective way to push others away and create isolation. Consequences of guilt and shame include low self-esteem, withdrawal, isolation, self-criticism, difficulty feeling enjoyment, anger, depression, intimacy difficulties, difficulty feeling empathy or compassion, and difficulty tolerating weakness and needing to be right.

It is not the event that determines whether something is traumatic to someone, but the individual's experience of the event."

(Jaffe, Segal & Flores Dumke, 2005)

Anger

Anger is a natural human emotion and in appropriate situations it can be valuable. When skilfully managed, it can motivate constructive action. Anger is not the same as aggression. Anger is a feeling that can lead to positive or destructive behaviour, whereas aggression is a behaviour that is usually seen as destructive. Problems arise when anger is suppressed or is too frequent, too intense or continues over too long a period of time. It becomes like a pressure cooker that builds up and explodes. This may lead to the person becoming aggressive: abusing or attacking to let off steam.

Anger is often used to cover up deeper feelings associated with the trauma experience such as fear, feeling weak or vulnerable, grief, sorrow and shame, anxiety and depression. As an externalising mechanism, anger most often deflects our own personal unhappiness onto others, projecting onto them the reason for our dissatisfaction with life. We can see anger, rather like an ice-berg, but have little idea what is below the surface.

Anger is often a feature in PTSD, especially when the traumatic event was deliberately inflicted by another human being. Tolerance to everyday situations (such as loud noises, mistakes, lateness and minor upsetting events) may be responded to with anger. This can be especially problematic in treatment and often leads to premature termination. Survivors who use anger as a deflector or defence against other emotions tend to have a reduced capacity for internal reflection and resolution of issues as they are more externally focused and more difficult to treat.

Problematic anger can be broken down into four components:

- Cognitive/perceptual
- Mood related
- Physiological
- Behavioural

Strategies to reduce anger can work on all of these factors (see section 7 for some ideas).

SECTION 6

Trauma And Substance Use

After experiencing a traumatic event, people may turn to substance use to cope with their feelings, intrusive memories and sleep problems. In these circumstances, alcohol and other drug use may be seen as self-medication in the short term, alcohol and other drug use may give some relief to the symptoms of trauma. If continued over time however, alcohol, tobacco and other drugs interfere with the brain's natural ability to process traumatic events. Hence, when trauma survivors reduce or cease their use, traumatic reactions become more intense and/or frequent releasing the accumulated unfinished business of the event's impact.

Our research report (see website) on Trauma, Alcohol and Drug Comorbidity (2011) concluded that the onset of traumatic stress disorder can typically precede the onset of substance abuse.

Alcohol and other drug use may appear to the user to reduce PTSD symptoms. Unfortunately, in the long term, prolonged and excessive use may compound problems creating a cycle of trauma and substance use. This is because it may induce symptoms such as anxiety, panic, depression. sleep disturbances, memory loss, relationship problems, social isolation, as well as contributing to difficulties at home and work, reducing the person's ability to learn and use more helpful coping strategies, and cause brain damage and physical illness.

Prescription medications are increasingly being abused or used for non-medical purposes. This practice cannot only be addictive, but in some cases also lethal. Commonly abused classes of prescription drugs include painkillers, sedatives, and stimulants. Among the most disturbing aspects of this emerging trend is its prevalence among teenagers and young adults, and the common misperception that because these medications are prescribed by physicians, they are safe even when used illicitly. The aforementioned website report states that: "As during the 'troubles' many women developed addictions to prescribed medication like Valium to deal with the depression they suffered as a result of the men they lived with being killed. Men dealt with the 'troubles' more with alcohol (Witness at the Centre for Social Justice Policy hearing (2010)".

*"It has always seemed unrealistic to expect trauma survivors to put down their coping mechanisms, even those that are unhealthy, prior to developing alternatives" (**Young 2010**)*

The high prevalence of prescription drug misuse is specific to Northern Ireland, in contrast with the UK, and recent evidence suggests that this could be largely associated with the management of illnesses associated with the 'troubles'.

Working with PTSD and co-existing conditions

Effective treatments have been well documented for PTSD:

- Psychotherapy, Prolonged Exposure and Cognitive Processing Therapy, CBT, Harm Reduction, Holistic Approaches (as described in this Resource Guide)
- Motivational interviewing/motivational enhancement, relapse prevention and twelve-step programs such as AA
- Eye Movement Desensitising Reprocessing Therapy (EMDR).

However, there has been limited research into effective treatment for PTSD and SUD together and more needs to be done on this.

Integrated treatment should aim to:

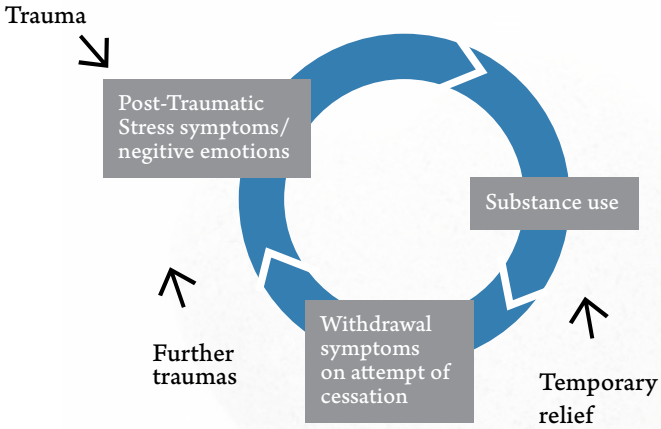
- Help the client achieve a level of control over their substance use
- Provide information and education on PTSD and symptom management

Foundations for safe trauma treatment

- First establish safety for the client within and outside treatment.
- Create a strong trust-based therapeutic relationship.
- Identify and build on the client's internal and external resources.
- Regard defences as resources.
- Never get rid of coping strategies and defences; instead, create more choices. (This is particularly significant with co-existing AOD use problems; skills development should occur in conjunction with substance reduction.)
- View the trauma system as a 'pressure cooker'. Always work to reduce, never increase, the pressure.
- Adapt the treatment to the client, not the reverse. This requires you to be familiar with several treatment models and understand when to refer to specialist treatment provider.

- Have a broad knowledge of theory — both the psychology and physiology of trauma and PTSD. This reduces errors and allows you to create tailored treatments that match individual client needs.
- Regard the client with their individual differences and do not judge them for non-compliance or failure of an intervention. Find another way. As the practitioner/clinician, you must be prepared, at times or even for a whole course of treatment, to lay aside any and all techniques and just talk with the client.

The Cycle of trauma and substance use



As a practitioner/clinician, you can develop your skills and experience to incorporate trauma recovery as an integral part of your provided treatment. Interventions may include: relationship building, creating safety, psychoeducation, distress reduction, affect regulation, resource building and cognitive interventions. This is incredibly important work that makes possible efficacy in the stages of work that follow. However, these later stages or `step treatment' will require only trained psychologists, social workers, occupational therapists and nurses, and they will need to have training in the specialist skills required for the treatment phase. Short courses suitable for AOD clinicians with clinical backgrounds are available to develop exposure therapy skills but close supervision is also necessary. Or you can collaborate with or refer clients to experienced treatment providers at the end of your Phase 1 or First Steps treatment or Stepped Care Model phase.

Not all service users/clients will be suitable to go through all the phases of trauma treatment and the amount of time it takes will vary depending on the individual, the severity and the age of the traumatic event and co-existing conditions. For some people suffering from complex trauma, this may never be possible or it may be a number of years until the person is ready to engage in this process. Before trauma processing can take place, stability needs to be established, skills and resources developed and boundaries constructed such that processing can be safe and effective.

SECTION 7

A Sample of Interventions

Experiencing a traumatic event and overcoming it can lead to positive psychological transformation. In your clinical role, you can support clients to transform their lives after a traumatic experience. This section gives an overview of a range of interventions that may be helpful when working with traumatised clients on distress reduction and affect regulation in the first phase of trauma treatment.

Remember that it is important to stabilise any substance use problems and develop alternative coping strategies for managing the mental health consequences of trauma before trauma memory integration occur. You can use your clinical AOD skills in motivational interviewing, harm reduction and relapse prevention in conjunction with the specific interventions outlined below. Psycho-education is an important part of treatment. Helping someone to understand what is happening to them, why it is happening and what can be done to help is essential to reassure them and give an idea of what to expect. The information in this resource gives a brief introduction to the interactions between traumatic stress and SUDs but it is recommended that clinicians seek out further resources and training.

Collaborate with the client to explore what may work best for them from the range of possible interventions outlined below and give onus to the client to find out more about specific techniques. If clients have chosen exercises, they may be more inclined to try them out. You might also want to make a collection of worksheets on techniques like breathing and relaxation or mindfulness. Clients can try them in the session and then take worksheets home as handouts to practise in their own time. There are many resources available in books, CDs on the internet and other places; it is quite appropriate to refer people there. Be aware, however that the quality and evidence base of resources on the web may vary widely so you will need to check where they are from and whether the techniques they describe are likely to be appropriate and helpful for trauma treatment.

It should be noted, that it is very important that workers are professionally and comprehensively trained. Without clear professional guidance and training workers can run the risk of retraumatising their clients.

"Trauma, whether personal or collective. threatens life and it takes life and requires healing with the help of humanity". ***Frank Ochberg***

Relaxation

There are many books, CDs, DVDs and websites explaining different techniques for both breathing and relaxation exercises.

It is helpful to introduce clients to a few different techniques. Have them practise exercises during the week and report back until they find something that suits their needs. It can be helpful to have longer techniques that are used at designated times and also a brief strategy that can be used in public for acute distress situations.

For example:

- short techniques include six-second breathing and diaphragmatic breathing;
- longer practices include progressive muscle relaxation and "creating a safe or special place"

Clients should be encouraged to practise daily until overall anxiety and other PTSD symptoms reduce. Practice also helps the client learn how to use techniques in situations before, during and after the triggering of trauma-related responses. Learning relaxation can be challenging for some people when first introduced. It is important to explain this and offer opportunities to discuss any difficulties openly then work together to find solutions. Initially the benefits might not be apparent, but persistent practice will lead to good results in the longer term.

e.g Circle a number to show how you are feeling now, when you think about the event.

0 1 2 3 4 5 6 7 8 9 10

no bad feeling — the worst feeling

It is helpful to ask clients to rate their distress levels before and after relaxation training using a Subjective Units of Distress Scale (SUDS) (Wolpe. 1958).

The scale rates from either 0 to 10 or 0 to 100 the intensity of distress experienced in the moment.

This is a good way to monitor the changes over time or before and after using a technique. Clients need to have mastered some techniques that assist them in controlling their distress levels if they are going to be able to participate in trauma memory integration later.

Mindfulness

Mindfulness has been adapted from Buddhist meditation for the clinical setting. The basic premise is to be awake and aware in the present moment and acknowledge and accept each thought, feeling and sensation just as it is. This can be a useful strategy to help clients deal with unhelpful responses to trauma, like living in past memories or future fear or worry that something bad will happen again. There are many professional development opportunities, resources and information available on mindfulness, but the most important thing to remember when assisting a client with all new techniques is that mastery comes from regular practice. Mindfulness often involves becoming more aware of your senses and surroundings when doing ordinary things such as walking: noticing without judgement what you see, how your body feels, what you can hear, what you are thinking about, smells, sounds and so on. Eating and even dishwashing are other simple daily activities that can be done mindfully. The process needs to be explained and rehearsed with the client. Mindfulness is a tool that assists with increasing a client's capacity to regulate and tolerate negative emotional states, and can change their relationship to their internal experience.

Grounding

Grounding exercises are used to anchor attention in the present reality. They are used in the moment when distressing thoughts or memories emerge or when a person feels anxious or distressed. There is a range of grounding exercises; these may be mental, physical or soothing. Encourage the client to try them out to see what works best for them.

- Mental grounding. This may include describing objects in the environment In detail using all senses, describing an everyday activity such as driving to work or brushing your teeth or repeating a grounding statement I am (name), I am (number) years old, I am safe here, today is (date or day)
- Physical grounding. This may include walking barefoot on grass or sand, running water over hands, pressing heels into the floor, holding a stone that's kept in the pocket, stretching or touching then naming objects.
- Soothing grounding. This might be putting on nice-smelling hand cream, thinking of favourite things (such as foods, animals, cars) and planning something nice for oneself like a bath or special meal.
- Encourage the client to be creative and work with them to come up with things that might assist in grounding them when they are distressed.

Cognitive Interventions

Cognitive Interventions. Part of experiencing a traumatic event is that currently held beliefs about self and/or the world are, in some way, shattered. Part of a trauma reaction might be that unhelpful new beliefs are constructed that may add to the ongoing distress. It is also possible that unhelpful thought patterns established prior to the PTE might aid in worsening the post trauma reaction. CBT (cognitive behavioural therapy) helps survivors to identify, challenge and modify biased or distorted thoughts and memories of their traumatic experience. It can also help tackle associated unhelpful beliefs about oneself and the world that may have developed as a result of the experience. Cognitive interventions enable the client to become their own therapist by learning a range of techniques based on the idea that what we think affects the way that we feel and we have the ability to control our thoughts and hence change how we feel about things. This results in a reduction of strong negative emotions. CBT interventions can be helpful in working with guilt, anger, shame, anxiety, depression and other elements of trauma. Cognitive interventions have also been shown to be effective in treating sleep disturbance, a common symptom of PTSD.

There are many good resources on CBT, including self-help books and online resources, although evidence suggests that supported CBT is more effective than self-help alone. It is critical that you have a good understanding of CBT techniques so you can teach these to clients; being unable to do so only lessens their impact.

Anger Management

Initially, establishing if anger is a problem and what triggers it is important. Knowing the signs (physical, psychological and behavioural) will help with identifying patterns. Keeping an Anger thought diary may help. The client can use this to explore the situation - when, where, who, the level of anger from 0 to 10 (when 0= relaxed and 10= extreme anger) - and identify any associated physical sensations. This may include what the client was thinking, what they did, what the feelings under the anger were and what the outcome was. Once early warning signs are identified, it is then possible to identify points where the client can intervene with a circuit breaker before the anger escalates. Possible 'circuit breakers' include momentary delay, taking time out, setting a time to deal with potentially anger-provoking situations and using calming or breathing techniques to reduce the tension in the moment.

CBT techniques can also be helpful when dealing with thoughts that induce anger and aggressive behaviours.

Other Strategies

Don't underestimate some of the simple things you can discuss and reinforce with clients to assist them in managing trauma. These include:

- having a good healthy diet
- regular exercise
- daily routine
- good sleep
- managing or reducing substance use
- limiting caffeine intake (as a psychostimulant. the effect of caffeine is to arouse the body's response somewhat similarly to anxiety and anger).

All of these things will support the client with managing their trauma and may be an important part of a treatment plan.

Sleep disorders are a common effect of trauma that can increase health problems in survivors. By recognising possible sleep disorders, you can work with clients to minimise or even eliminate these problems. Addressing sleep disorders will likely result in:

- lower levels of trauma-related symptoms
- greater ability to manage other symptoms and engage in treatment and life
- improved overall health.

Medications can be helpful for managing some PTSD symptoms. Prescribed especially where severe symptoms occur, include antidepressants, anxiolytics and sleeping medications. Be sure that client is aware that if tricyclic antidepressants or benzodiazepines are prescribed, there is a danger of overdose when combined with alcohol or other central nervous system depressants.

SECTION 8

Clinical/Practitioner Self Care & Vicarious Trauma

Vicarious Trauma

In 1990 Mccann and Penman coined the term "vicarious traumatisation" to describe the potential psychological impact on clinicians working with people who have experienced severe trauma. This term is now also used to describe the negative health experience of people who work with traumatised people. As a clinician, it is important that you are aware of the possibility of vicarious trauma and have good self-care and supervision when working with this client group. Vicarious trauma is different from compassion fatigue and burnout but all three must be kept in mind. Take care to look after yourself and maintain professional boundaries; thus will help to ensure that you remain empathic, compassionate and useful to the people who use your services. When working with clients on any issue it is important to have a sound evidence-based theoretical practice. This provides structure and clarity in working with trauma and substance use problems. It assists with formulation and treatment planning and helps you to maintain good boundaries within treatment, which will support both the client and yourself.

"There is a cost to caring. Clinician Self-Care professional who listen to clients' stories of fear, pain or suffering may feel similar fear, pain and suffering because they care."
(Sabin-Farrell & Turpin, 2003)

Trauma treatment touches on sensitive issues and, at times, the client may become distressed. This may cause you to feel uncomfortable. It can be re-assuring to remember that the evidence suggests, that creating a space where the difficult memories can be explored is a helpful and crucial part of treatment. Your role is to provide a safe environment for the client to begin treatment and help prepare them so that they feel secure and ready to do the necessary work.

Integration of painful memories is part of the next steps and phases of treatment and requires specialist interventions or referrals to specialist services, and should not be attempted prior to completing early stages by practitioners/clinicians who do not have the necessary skills and support. No matter how experienced you are as a clinician, good and regular clinical supervision is imperative. It helps you to unload, strategise, deal with transference and parallel process issues, and get clarity and guidance in working with traumatised clients. Self-care outside of work is important. Rest, exercise, eat well, limit your own substance use, live a balanced lifestyle and use personal support networks. Don't bottle things up and get professional help if stress becomes too much. Practice what you preach: good meals, sufficient rest, exercise and alteration of routine. As trauma author Frank M Ochberg points out that, "Clearly there is no single prescription for the hurting that comes with helping others. But each one of us is also a source of comfort, information and inspiration".

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