

# Putting together the pieces

Responding to trauma  
and substance use

INSPIRING ALCOHOL  
& OTHER DRUGS  
TREATMENT & EDUCATION

Re | Gen™

 UnitingCare

## About ReGen

ReGen is the lead alcohol and other drugs (AOD) treatment and education agency of UnitingCare Victoria and Tasmania.

Our purpose is to promote health and reduce alcohol and other drug related harm.

We recognise that AOD use may not be the only issue that our clients are dealing with and we provide individualised treatment, education and support to enhance their lives and reduce harm. In combination with our workforce training and public advocacy, we support social justice and sustainable change at an individual, community and systemic level.

In June 2012 we changed our name from UnitingCare Moreland Hall to UnitingCare ReGen (ReGen) to give people a better idea of who we are, what we do and how we work. ReGen is a not-for-profit which has been supporting people with alcohol and other drug issues and their families since 1970.

All our treatment and support services are free. There are fees for some of our training and educational group programs.

## Acknowledgements

ReGen would like to thank contributors for their generous support and for sharing their expertise.

Particular thanks to: Tony McHugh, Manager at Post Trauma Victoria

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ReGen acknowledges funding of this resource provided by the Australian Government Department of Health and Ageing.

Published 2012 by UnitingCare ReGen  
ABN 96 525 412 680

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## Abbreviations

AOD	Alcohol and Other Drugs
ASD	Acute Stress Disorder
BAD	Bipolar Affective Disorder
CBT	Cognitive Behavioural Therapy
DESNOS	Disorders of Extreme Stress Not Otherwise Specified
DID	Dissociative Identity Disorder
DSM	Diagnostic and Statistical Manual of Mental Disorders
GLBTQI	Gay, Lesbian, Bisexual, Transgender, Queer, Intersex
ICD	International Classification of Diseases
PTE	Potentially Traumatic Event
PTG	Post-Trauma Growth
PTSD	Post-Traumatic Stress Disorder
SU	Substance Use
SUD	Substance Use Disorder
SUDS	Subjective Units of Distress Scale
TRMHD	Trauma-related Mental Health Disorder



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“Healing is a matter of time,  
but it is sometimes also  
a matter of opportunity.”

(Hippocrates, 460–370 BC)

## Who is this resource for?

*Putting Together the Pieces* is written for clinicians in the alcohol and other drugs (AOD) sector, but will be useful for anyone working with clients who experience the co-morbid effects of trauma-related mental health disorders (TRMHDs) and substance use issues. This includes mental health workers as well as people who work with refugees, asylum seekers, gamblers and anyone who has experienced natural disasters and other forms of loss.

This introductory resource aims to give clinicians clear direction and confidence when working in this area. We recommend that all AOD clinicians seek further education around specific trauma interventions. The AOD sector is very broad, with its workforce comprising many professions and disciplines. This resource has been developed with that breadth and variety of professions in mind. Within this booklet, interventions are divided into three phases. All AOD workers should be able to provide phase one interventions – supporting clients experiencing trauma.

It is advised that only trained psychologists, social workers, occupational therapists and nurses can work with phase two and three interventions (See section 6 for information about the stages of trauma therapy) and that would only be advised if the workers have been trained in working with trauma and have clinical supervision and support.

While this resource is targeted at clinicians, it contains information that also may be helpful for clients and their families working toward recovery from trauma-related issues.

Please take the time to complete our online feedback survey at [www.regen.org.au](http://www.regen.org.au). Your feedback will help us improve this resource and develop further professional development tools.

**“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)*



Descriptions of trauma are as old as myth. Yet the psychiatric community has not always sympathised with the reactions of people affected by terrifying events nor had a clear understanding of how traumatic events affect people. It wasn't until the return of large numbers of US servicemen from Vietnam in the 1970s that the picture of post-trauma effects became so clear that they commanded attention and were included in the psychiatric nomenclature. Post-traumatic stress disorder (PTSD) was included in the American Psychiatric Association's 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 (TRMHDs) are often unrecognised by AOD clinicians and other healthcare practitioners. Co-occurring post-traumatic stress symptoms and substance use is a very common co-morbid picture, and together can exacerbate other related symptoms such as anxiety and depression.

## Trauma in AOD treatment

Often people presenting for substance use treatment are experiencing the healthcare system for the first time. As a clinician, it is important that you recognise the effects of trauma so as to get treatment “right” from the beginning.

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 6).

Ongoing misuse of alcohol and other drugs can put users in situations that are potentially traumatic. Some examples include increased risk of assault, overdose (of self and significant others), road traffic accidents or sexual abuse. Even if a person has no early age trauma-related mental health issues, they may be inadvertently exposed to traumatic situations as a result of their substance use.

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 AOD clinicians

In your role as an AOD clinician, there are many ways you can assist a client to recover from the psychological effects of trauma. It is important that these are seen as a fundamental part of your AOD treatment within a shared, collaborative care environment. Your role may include screening for TRMHDs, 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 AOD use (see section 1)
- screening and assessment for TRMHDs (see section 1)
- issues related to creating a safe treatment setting and establishing rapport (see section 2)
- how to recognise guilt, shame and secrecy associated with the negative consequences of traumatic experiences (see section 5)
- the importance of a staged approach to treatment (see section 6)
- interventions and tools for treating co-morbid issues (see section 7)
- knowing when to refer and how to support transitions between services (see section 6)
- the importance of self-care and avoiding vicarious trauma (see section 8)

## Section 1

### What is 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.

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, fire) 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 a TRMHD because memory storage and retrieval will be compromised. Substance use interferes with a person's ability to manage a potentially traumatic event (PTE).

**"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)

#### Common reactions to traumatic events

Most people experience one or more traumatic events in their lifetime but only a small proportion of people will go on to suffer TRMHDs. Prevalence statistics around TRMHDs are not conclusive as information collected is skewed by factors such as delayed onset, co-morbid conditions, gender differences, low levels of help seeking and lack of knowledge by professionals and the general public.

**"... 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.

A TRMHD will be more or less likely to occur, depending on the presence of a range of factors outlined below.



## 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 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 is.

## Symptoms of post-traumatic distress

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.

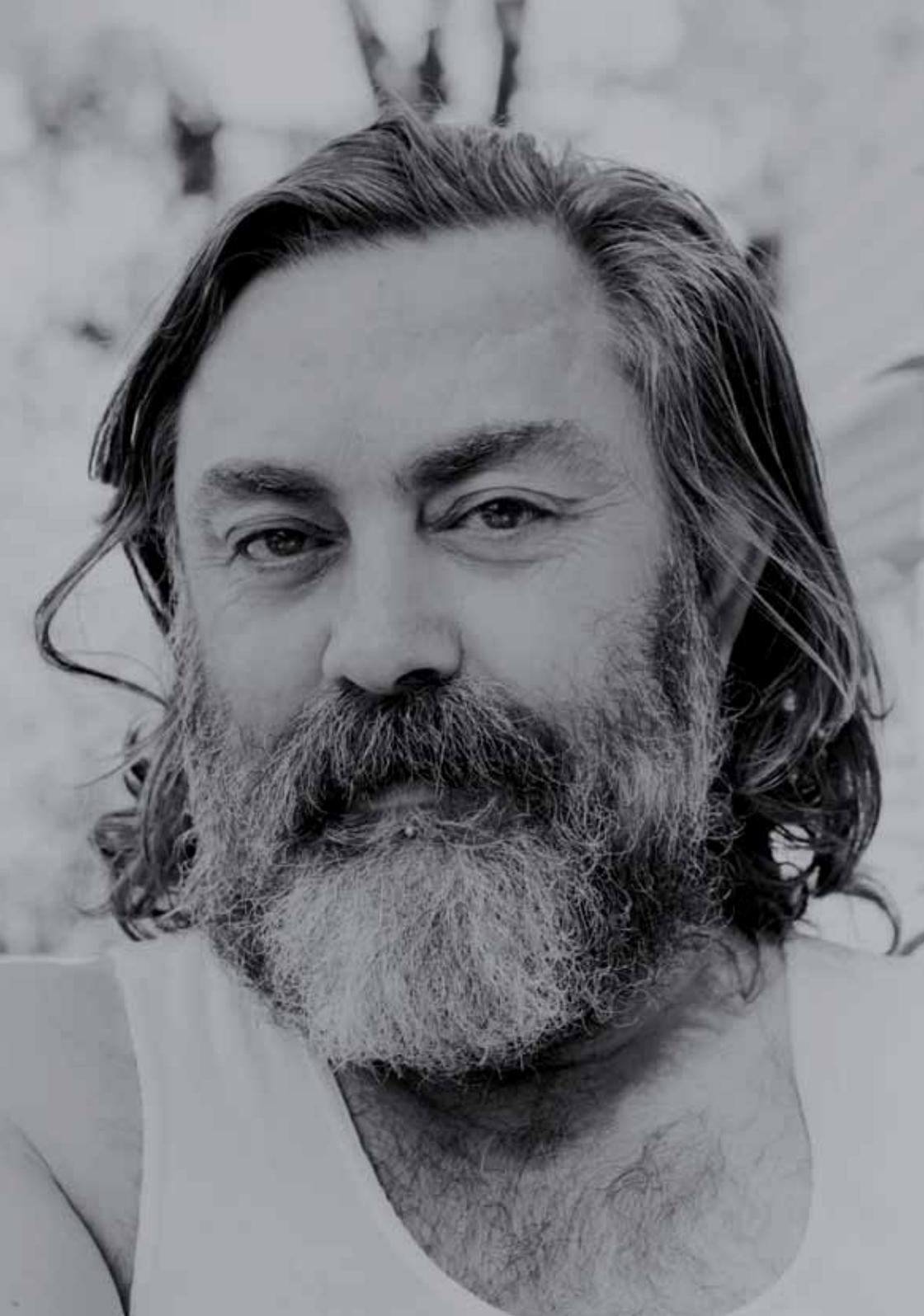
Symptoms include the following:

- **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 a TRMHD.





## 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 "fires". 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 (ACG), 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 unaccessible or unconscious memory.

If the person then experiences something similar emotionally or sensorially to what happened at the time of the event a stress response may be triggered that is not connected by the person to the original event but has the same heightened feeling. Hence, memories are not necessarily repressed as is commonly thought but, rather, are never formed properly at the time of the trauma experience.

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.

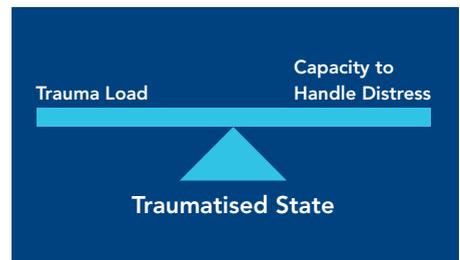
## Trauma loading

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 natural disaster such as a bushfire, tsunami or earthquake, may have a TRMHD reaction. 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.

**"Traumatic events can get under your skin and literally alter your biology."**

(Toyokawa, Uddin, Koenen & Galea, 1982)



“In seeking to understand the origins of presenting problems, the practitioner should routinely enquire about any experience of stressful or traumatic events, recently or in the past.”

(ACPMH, 2007)

## Section | 2

### Screening

### for | trauma

TRMHDs are very common among the AOD treatment population. Clients may not mention that they have experienced a PTE 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 TRMHDs are overlooked, this may negatively impact on treatment effectiveness.

Using a range of tools is the most helpful way 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. Trauma assessment is detective work; you'll need to look for themes and underlying childhood trauma.

Screening for trauma is an essential part of your overall AOD work.

Asking if trauma has occurred:

- 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 clinicians with specialist training.*



“There is no evidence clients resent or object to being asked about a history of childhood sexual abuse.”

(Galllop, McKeever, Toner, Lancee & Lueck, 1995)



### 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 it. 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” it as part of more advanced treatment (e.g. exposure therapy). These issues are explained in more detail in section 4.*

### 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.
- Practise asking or 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 of a TRMHD.

## Screening tools

There are a number of public domain screening tools that directly address trauma. Mental health tools that screen for emotional distress, such as PsyCheck, 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 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.

Here are two examples of screening tools for PTSD you may find useful to add to your toolkit.

### **Short Screen**

This is an example of a screening measure that has been proven to be effective in clinical trials (empirically validated). The client is asked to answer “Yes” or “No” to seven questions. According to the authors, if four or more questions are answered positively, a PTSD diagnosis is likely (ACPMH 2007).

- 1 Do you avoid being reminded of the experience by staying away from certain places, people or activities?
- 2 Have you lost interest in activities that were once important or enjoyable?
- 3 Have you begun to feel more distant or isolated from other people?
- 4 Do you find it hard to feel love or affection for other people?
- 5 Have you begun to feel that there is no point in planning for the future?
- 6 Have you had more trouble than usual falling or staying asleep?
- 7 Do you become jumpy or easily startled by ordinary noise or movements?

Source: Breslau et al. (1999)

### **PTSD Checklist for Civilians**

Another public domain tool that is commonly used is the PTSD Checklist for Civilians (Weathers et al., 1993).

This is a 17-question screen that is self-administered. If the client scores positively, the tool can be re-administered during or after treatment to assess for changes in presentation and treatment effectiveness. It can be found on the internet.



## Section | 3

### Trauma-related

### mental | health

### disorders

“Over the past decade, the world health community has witnessed an explosion in the knowledge of trauma and its multi-faceted impact on the human brain and its psyche.”

(Bearup, 2010)

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



“Panic Disorder and Major Depressive Disorder (PD & MDD) are the most commonly occurring post-traumatic disorders, apart from PTSD.”

(Amstadter et al., 2009)

## Anxiety disorders

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 (ASD) and post traumatic stress disorder (PTSD)**

Are the anxiety disorders that are directly linked with trauma experience and are outlined in more detail below.

## Acute stress disorder (ASD)

Acute stress disorder 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)

## Post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder is the most widely known trauma-related disorder. According to the DSM-IV-TR (APA, 2004), PTSD may be diagnosed one month after 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.

## Mood disorders

An important differential diagnosis for PTSD is that of bipolar affective disorder (BAD). BAD (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.

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.

Conducting a thorough risk assessment should be standard practice with every client presentation. Clinicians should also consider a referral to a GP to investigate whether medication could assist in treating depressive symptoms.

## 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 dissociative 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.

Dissociative identity disorder (DID), previously called multiple personality disorder, is the most severe and controversial form of dissociation. It is very rare. Classic descriptions refer to the coexistence of two or more personality states within the same person. The person is usually not aware of these personalities and experiences them as memory lapses. The other personalities may have different body language, tone of voice, genders, ages, outlook on life and memories. For people with DID, switching to another personality state commonly occurs when under stress. Treatment strategies are aimed at increasing integration of the personalities and reducing dissociation.

Dissociative symptoms are included in the criteria for ASD, PTSD and somatisation disorder.

## 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 person's 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 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 trauma 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.

Currently complex trauma and DESNOS are not identified in either the DSM or ICD, although trauma specialists consider this important. They have compiled some criteria around alterations in affect regulation, consciousness, relationships, meaning, self-perception and somatisation that may be included in the future.

## Personality disorders

Repeated childhood traumas may lead to a personality disorder. This is not to say that everyone who experiences a traumatic situation will develop these problems, but it may increase a person's vulnerability. It has been suggested that early and severe trauma, in particular, can cause personality difficulties.

A number of personality disorders, including borderline personality disorder (BPD) and antisocial personality disorder (ASPD) have been associated with early childhood trauma. These disorders are quite different to PTSD. People with BPD and ASPD have often experienced significantly compromised attachment to an important caregiver as a child, which has led to difficulty forming and maintaining stable relationships in later life. Trauma is not the single cause of personality disorders; there are a number of factors that may contribute such as genetics and inheritance, family circumstances, brain chemical imbalance (which may also be a factor of early childhood trauma) and life experiences (for example, childhood abuse, neglect or separation from caregivers or parents who are over or under-involved and substance-misusing parents).





### Psychotic disorders

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. 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.

## Substance use disorders

Drug and alcohol misuse very commonly co-occurs with PTSD and other TRMHDs. The presence of comorbid 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 in AOD treatment and few clients receive specific trauma-related interventions, although this is a developing field.

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.

“A history of invasion, the ongoing impact of colonisation, loss of land and culture, racism within the wider Australian community, family separations and deaths in custody are all examples of trauma and loss experienced by indigenous Australians.”

(Aboriginal Mental Health First Aid Training and Research Program, 2008)

### Generational trauma

Trauma that was suffered by ancestors can also contribute to a cultural level of trauma symptoms. This is known as generational trauma. Atrocities such as the Holocaust, slavery and the conquest of First Nation peoples still reverberate in individuals, families and societies as a whole. Colonisation and immigration have often led to a sense of rootlessness and loss of tradition. Rediscovering family history or revaluing one’s ethnic history and identity can be important steps in reclaiming power and soul and healing the trauma so that it is not passed down to future generations.

This is particularly relevant for The Stolen Generation of Indigenous Australians (although other groups such as the Jewish people, Bosnians and other cultural groups who have experienced atrocities may also experience generational trauma). Because of the trauma-loading effect (see section 3), Australia’s First People may be more vulnerable to other traumatic events.

“Be aware of what constitutes culturally appropriate behaviour after trauma or loss. For instance, it is not unusual for Aboriginal people to see, hear or talk to spirits of deceased loved ones.”

(Aboriginal Mental Health First Aid Training and Research Program, 2008)

## Children and families

Intergenerational trauma may occur to the children of parents suffering the symptoms of PTSD. Research on the children of Holocaust survivors, Vietnam veterans and (more recently) Indigenous populations across Australia indicate that, when living with someone with PTSD, families have to “walk on eggshells”. This can disrupt normal development for children and may not provide a safe environment to grow up in.

Partners and family members of trauma sufferers may develop their own problems, as a way of surviving. Some may mirror PTSD symptoms, such as disconnecting from their own experiences and emotions, or may turn to substance use. A partner may learn to “switch off” for fear of escalating aggressive or abusive behaviours and a vicious cycle is set up where unhelpful coping mechanisms are reinforced. Family members may also adjust their own lives in an attempt to support or avoid the person with PTSD or to conceal difficulties from those outside the family.

## GLBTQI

“In comparison with the general population, GLBTQI Australians are subject to a number of poorer health outcomes such as depression, anxiety, drug and alcohol use which can be largely attributed to the discrimination and in some cases physical and verbal abuse that they experience across the country.”

(NSW Attorney General’s Department, 2003)

The gay, lesbian, bisexual, transgender, queer and intersex (GLBTQI) population has higher rates of AOD use, compared to the general population (according to the 2005 National Health Alliance survey). GLBTQI 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 (Howard & Arcuri, 2006). Although there is little specific research into co-morbid 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.

## Section 5

### Trauma-related

### emotional states

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 themselves, such as compulsive caregiving, withdrawal and isolation, fierce self-sufficiency or guardedness and suspiciousness.

“The emotional state of guilt or regret is produced when individuals evaluate their behaviour as failure but focus on the specific features or actions of the self that led to failure. Unlike the focus in shame on the global self, the focus in guilt is on the self's actions and behaviours that are likely to repair the failure.”

(Lewis, Haviland-Jones, 2004)

#### 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 themselves for what went wrong when they couldn't have been responsible and forgive themselves 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.



## 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.

## Anger

Anger is a natural human emotion – 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. Like an iceberg, we can see anger but have little idea what is below the surface.





Healey, Stoeckel, McHugh, 2011

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

“Incidence estimates suggest the rates of substance abuse among people with PTSD may be as high as 60–80 per cent, while rates of PTSD among substance abusers is between 40–60 per cent.”

(Donovan & Padin-Rivera, 1999; Keane, Gerardi, Lyons & Wolfe, 1998; Kofoes, Friedman & Peck, 1993)

Trauma and addictive behaviours are often closely related. Epidemiological data drawn from the Australian National Mental Health and Well Being study (Creamer, Burgess & McFarlane, 2001) found that, in chronic cases of PTSD (those lasting longer than three months), 37 per cent of men and 12 per cent of women also met criteria for alcohol misuse/dependence and 22 per cent of men and 15 per cent of women met criteria for drug misuse/dependence. (ACPMH, 2007)

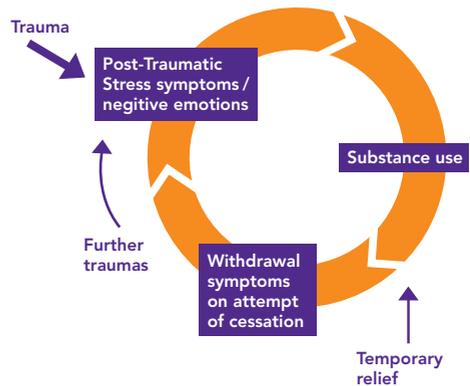
After experiencing a traumatic event, people may turn to substance use to cope with their feelings, intrusive memories and sleep problems. In these circumstances, alcohol and other drug use may be seen as “self-medication”.

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.

Alcohol and other drug use may appear to the user to reduce PTSD and TRMHD 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.

If clients have a long history of alcohol, inhalant, opiate or benzodiazepine use, it may be useful to have a neuropsychological assessment to check for brain damage or cognitive impairment, as this will affect how treatment is delivered.

### The cycle of trauma and substance use



## Working with PTSD and co-morbid SUD

“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)

Effective treatments have been well documented for PTSD (prolonged exposure and cognitive processing therapy) and SUD (CBT, harm reduction, motivational interviewing/motivational enhancement, relapse prevention and twelve-step programs such as AA).

However, there has been limited research into effective treatment for PTSD and SUD together. Current literature suggests integrated treatment that incorporates exposure-based techniques represents best practice.

The ACPMH guidelines (2007) recommend that both conditions should be treated simultaneously. However, the client should demonstrate the capacity to manage distress without substance use prior to the trauma-focused component of the work commencing and should also be able to participate in treatment without being drug-affected.

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
- delay the trauma-focused component of treatment, such as exposure, until stabilisation of substance use has occurred

## Foundations for safe trauma treatment

- First establish safety for the client within and outside treatment.
- Create a strong trust-based therapeutic relationship.
- Both you and the client must be confident in using emotional regulation skills before exposure therapy can occur. Exposure therapy must only be carried out by a clinician trained in doing so.
- Identify and build on the client's internal and external resources.
- Regard defences as resources. Never “get rid of” coping strategies/defences; instead, create more choices. (This is particularly significant with co-morbid 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 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.

(Adapted from Rothschild, 2000)

AOD clinicians can do significant work at Phase 1



With extensive professional training and clinical supports AOD clinicians could work at all three phases



## Three phases of trauma treatment

### Phase 1: Safety, stabilisation and symptom reduction

Includes actual and perceived safety, development of emotional awareness, emotion regulation, distress tolerance and therapeutic alliance.

### Phase 2: Processing of trauma memories

Involves revisiting and re-examining the traumatic events and the associated relational cognitions.

### Phase 3: Intergration and reconnection

Involves establishment of a new way of seeing the self, improved self-esteem and repair/enlargement of interpersonal and social connections.

**Adapted from Rothschild (2000)**

## Three phases of trauma treatment

It is standard practice in the treatment of TRMHDs to work using a graduated approach that involves three treatment stages (see above). This approach is advocated by leaders in the TRMH field from a variety of frameworks, including psychodynamic and psychoanalytic (as represented by Ari Shalev and Charles Marmar), cognitive behavioural (as represented by Terry Keane and Edna Foa) and more eclectic approaches (as represented by Bonny Green, Babette Rothschild and John Briere). It is also supported in the multiple international and local guidelines that apply to the field.

As an AOD clinician, you can develop your skills and experience to incorporate Phase 1 of trauma recovery as an integral part of your AOD 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, only trained psychologists, social workers, occupational therapists and nurses should work with Phases 2 and 3, and they will need to have training in the specialist skills required for the second 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 Phase 1.



### Assessing the best approach for a client

Not all 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-morbid conditions. For example, trauma processing (Phase 2) is not always indicated. For this to occur, discreet traumas must be able to be recognised by the client. 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.

It is now recognised that exposure therapy is best practice for working through the trauma and its effects ("trauma memory integration"). However, this requires specialist training and occurs in Phase 2 of treatment. It would not be expected that you would carry out this phase of treatment without extra training; referral to a specialist would be indicated here. Section 9 has information on where you can access training in trauma exposure therapy and also organisations to which you can refer clients.

“Post traumatic Growth (PTG) is the experience of substantial positive psychological change resulting from the struggle to overcome highly challenging life circumstances.”

(Tedeschi & Calhoun, 2004)

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 at Phase 1 before trauma memory integration can 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 TRMHDs and SUDs but it is recommended that clinicians seek out further resources and training (see section 9).

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.

Also included in this section is a brief explanation of exposure therapy, which is a Phase 2 treatment, to help you understand what a client would experience if referred for further treatment so that you will then be able to assist in preparing them for referral. Or if you decide to source further training on exposure this section will outline what you would learn. It should be noted, that it is very important that workers are professionally and comprehensively trained on exposure training before attempting this work. *Without clear professional guidance and training workers can run the risk of retraumatising their clients.*

## 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.

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.

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



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, smoking or 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

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 TRMHDs.

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.

## Exposure

Exposure treatment was initially developed by Joseph Wolpe in the 1950s to treat anxiety disorders. The basic premise of exposure is a process of habituation, with the premise being that if the person can be kept in contact with the anxiety-provoking situation for long enough, their anxiety will reduce. Exposure occurs within Phase 2 of recommended treatment for trauma, and specialist training is required to conduct it. As an AOD clinician, you would be expected to refer clients for this treatment if you have not been trained in the technique. In all cases, substance use must be stabilised prior to commencing exposure.

Exposure can be carried out in imagination or live (in vivo):

- **Imaginal exposure (exposure in imagination)**  
Involves the client being asked to recount the traumatic experience in detail including sights, sounds, smells, somatic sensations, thoughts and emotions as well as their reactions (physical, behaviour and psychological). In the treatment of trauma disorders, particularly PTSD, the feared stimuli is often cued or unbidden memories of the traumatic event; imaginal exposure can help in addressing these.
- **Live exposure**  
May involve going to the place in which the traumatic event occurred.

Before exposure can occur, the client must feel safe and have developed techniques that can be used to manage anxiety that arises from recounting the traumatic event. You can prepare clients for exposure by working with them to learn relevant techniques during Phase 1 of their trauma treatment. These early techniques are not used during the exposure, as it is important for the client to experience “sitting in” the memory so that they are able to work through the trauma and its impacts. Phase 1 techniques may be used again, after exposure, if the client remains distressed or where (after much practice with a specialist treatment provider) the client undertakes self-exposure.

**“The majority of trauma survivors in several studies report some type of disordered sleep.”**

(Kendall-Tackett, 2007)

## Other strategies for managing trauma

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 hygiene
- 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
- a 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 "psychotropics", 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. Benzodiazapines are only useful short term and if prescribed for continual use can actually start causing some problematic symptoms.





**“There is a cost to caring. Professionals who listen to clients’ stories of fear, pain or suffering may feel similar fear, pain and suffering because they care.”**

(Sabin-Farrell & Turpin, 2003)

**“The perfect man of old looked after himself first before looking to help others.”**

(Chuang Tzu, c.360 BC – c.275 BC).

### Vicarious trauma

McCann and Pearlman coined the term “vicarious traumatization” in 1990 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; this will help to ensure that you remain empathic, compassionate and useful to the people who use your services.

### Looking after yourself

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.

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 Phase 2 of treatment and requires specialist interventions or referrals to specialist services, and should not be attempted prior to completing Phase 1 or by 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.

## Resources

### [Austin Health – Post Trauma Victoria](#)

[www.trauma.org.au](http://www.trauma.org.au)

300 Waterdale Road  
Heidelberg West  
Victoria Australia 3081

Phone (03) 9496 4138

Statewide service, based in Melbourne.

Provides group and individual psychiatric and clinical psychology treatment, professional development and training, supervision and primary, secondary and tertiary consultation.

### [Australian Centre for Posttraumatic Mental Health, The University of Melbourne](#)

[www.acpmh.unimelb.edu.au](http://www.acpmh.unimelb.edu.au)

Phone (03) 9936 5100

Email [acpmh-info@unimelb.edu.au](mailto:acpmh-info@unimelb.edu.au)

Provides research,  
publications and training.

Foundation House – The Victorian  
Foundation for Survivors of Torture Inc.

[www.foundationhouse.org.au](http://www.foundationhouse.org.au)

6 Gardiner Street  
Brunswick  
Victoria Australia 3056

Phone (03) 9388 0022

Email [info@foundationhouse.org.au](mailto:info@foundationhouse.org.au)

Offices also in Dandenong, Sunshine and Ringwood; services available to some rural and regional centres across Victoria.

Provides a range of services to people from refugee backgrounds who have survived torture or war-related trauma including counselling, advocacy, family support, group work, psycho-education, information sessions, complementary therapies, referral, training and education.

The Domestic Violence  
Resource Centre (Victoria)

[www.dvrcv.org.au](http://www.dvrcv.org.au)

292 Wellington Street  
Collingwood  
Victoria Australia 3066

Phone (03) 9486 9866

Email: use online form

on DVRCV website

Statewide service, based in Melbourne.

Provides online information, training courses for clinicians, specialist library, newsletter, publications and pamphlets.

Centres Against Sexual Assault  
(CASAs)

[www.casa.org.au](http://www.casa.org.au)

Phone 1800 806 292 (Sexual Assault  
Crisis Line, 24-hours)

Email: [ahcasa@thewomens.org.au](mailto:ahcasa@thewomens.org.au)

Statewide service, with 15 centres across Victoria.

Most CASAs see female and male victims of sexual assault and family violence, both adults and children. All CASAs offer 24-hour response, individual counselling, group programs secondary consultation and programs for young people with sexually abusive behaviours.

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