WORKSHOP

Concurrent Substance Use and Trauma

Overview of the Workshop

Session 1

1. **Concurrent substance use disorder (SUD) and trauma/ posttraumatic stress disorder (PTSD)**
   - Epidemiology, possible pathways, clinical impact
   - Gender (womens') issues
2. **Review of PTSD**
   - Diagnostic criteria of PTSD
   - Complex PTSD

Session 2

1. **Informal assessment**
   - General Assessment and interviewing strategies
2. **Formal assessment of**
   - Trauma exposure
   - Trauma agnosind PTSD symptoms
   - PTSD diagnosis

Overview of the Workshop

Session 3

1. **Treatment approaches for individuals with concurrent substance use and trauma**
   - Pharmacotherapies, exposure based treatment for PTSD
   - Integrated treatment programs
2. **General trauma informed practices**
   - Intake practices and engagement
   - Empathic listening and responding

Session 4

1. **Therapeutic techniques to cope with trauma symptoms**
   - Distress rating scale
   - Breathing and progressive muscle relaxation exercises
   - Practice in small groups
   - Discussion of experiences

Overview of the Workshop

Sessions 5 & 6

1. **Therapeutic techniques to cope with trauma symptoms**
   - Grounding, safe space, and trauma box exercises
   - Practice in small groups
   - Discussion of experiences
2. **Sleep and nightmares**
   - Relationship between sleep, substance use, and trauma
   - Nightmares in PTSD, treatment of PTSD related nightmares

Session 7

1. **Concurrent trauma and SUD in relationships**
   - Parenting issues, transgenerational trauma
   - Intimate relationships, interpersonal violence (???)
2. **Feedback and wrap up**

SESSION 1

Introduction to Concurrent Substance Use and Trauma

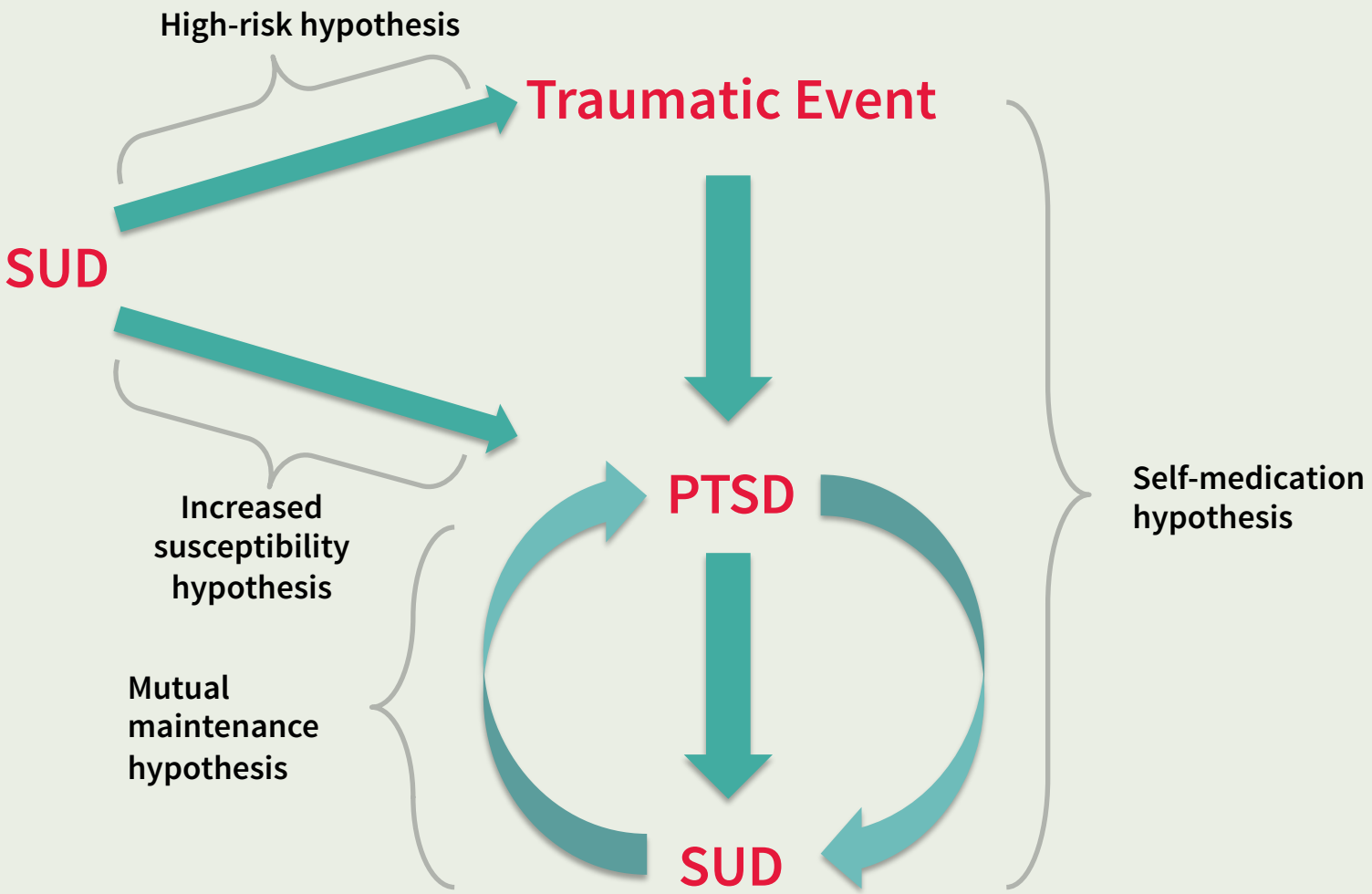
Today's Agenda

1. **Introduction to concurrent substance use and trauma/PTSD**
   - Epidemiology
   - Possible pathways
   - Clinical impact
   - Gender (womens') issues
2. **Review of PTSD**
   - DSM-5 diagnostic criteria of PTSD
   - Complex PTSD

The SheWay Study

- **31 adult women who were struggling with substances during pregnancy, and had given birth in the past 5 years.**
- **Measures:**
  - Childhood maltreatment;
  - Adult sexual, physical, and emotional abuse;
  - Psychological distress;
  - Severity of PTSD symptomatology.
- **All women reported experiences of childhood abuse and/or neglect, as well as adult abuse; multitype maltreatment was common.**
- **High general and/or PTSD related distress.**

How are Trauma and Substance Use Related?



Impact on Clinical Picture and Treatment Outcome

➔ **Individuals with PTSD-SUD:**

- More severe clinical symptoms, higher rates of additional psychiatric disorders and poorer physical health.
- Appear to have less benefit from standard SUD interventions ➔ poorer treatment outcome and higher SUD relapse rates.
- Persistence of PTSD symptoms in SUD treatment clients predicted substance use over the follow-up period.
- Attending PTSD treatment following discharge from a SUD program was associated with long-term SUD remission.

Gender-Specific Issues

- Women have lower rates of substance use disorders and prefer different substances than men.
- Women experience different types of traumatic events and have higher rates of PTSD than men.
- Other clinical issues associated with PTSD-SUD differ between women and men (e.g. additional comorbidities, symptom type and severity).
- Some studies indicated that substance use may be more likely to precede trauma in men than in women.

PTSD Definition

- **A mental disorder (defined in the DSM) that is a direct result of experiencing a traumatic event**

- **4 key symptom clusters:**
  - Intrusions, re-experiencing
  - Avoidance
  - Psychological changes
  - Hyperarousal

PTSD - DSM

A. Traumatic event

Actual or threatened death or serious injury, or sexual violence that occurred

- to the person directly,
- to another individual that the person observed,
- to a close relative or friend,
- repeatedly or through extreme indirect exposure

B. Intrusion symptoms

- Memories
- Distressing dreams
- Dissociative flashbacks
- Intense emotional and physiological response to reminders

PTSD - DSM

C. Avoidance

- of internal reminders (memories, thoughts, feelings)
- of external reminders (e.g., people, places, objects, situations)

D. Negative changes in mood and thinking

- Inability to remember aspects of the trauma
- Negatives beliefs about oneself, others, or the world
- Blame of self or others for causing the traumatic event or its consequences
- Loss of interest in activities
- Feelings of detachment or estrangement
- Persistent negative emotions, inability to experience positive emotions

PTSD - DSM

E. Hyperarousal symptoms

- Irritability or angry outbursts
- Reckless or self-destructive behaviours
- Being constantly on guard
- Easily startled
- Problems with concentration
- Sleep disturbance

Other criteria: duration > 1 month, functional impairment, not attributable to other factors

Complex PTSD

- **Effects of prolonged, repeated trauma**
- **Usually involves some form of 'captivity'**
  - Examples: concentration camps, political prisoners, kidnappings, cults, sex work, abusive families
- **Term coined by J. Herman (1992)**
- **3 areas of disturbance:**
  - Complex, diffuse, persistent symptoms
  - Changes in personality and relatedness
  - Vulnerability to repeated harm (self or others)

Complex PTSD

→ **Symptoms**

- Somatization: headaches, gastro-intestinal disturbances, chronic pain syndromes
- Dissociation
- Affective instability: depression, angry outbursts

Complex PTSD

→ **Personality changes**

- Extreme dependency
- Learned helplessness

→ **Identity changes**

- Loss of sense of self
- Unstable sense of self
- Self as non-human, evil, or flawed

Complex PTSD

→ **Vulnerability to repeated harm**

Survivors of childhood abuse at higher risk for:

- Self-mutilation
- Revictimization
- Abusive marital relationships
- Victimization of others (men)

Complex PTSD – Criticism

- **Considerable overlap of clinical features with borderline personality disorder (BPD)**
- **Overlap between PTSD and BPD**
  - Simple PTSD in 25-58% of individuals with BPD
  - BPD in 10-76% of individuals with PTSD
- **Proponents argue PTSD is less stigmatizing than BPD**
- **Critcism points to risk of overpathologizing or overmedicalizing normal reactions to adverse events that are part of the human condition**

SESSION 2

Assessment

Today`s Agenda

1. **Informal assessment**
   - General assessment and interviewing strategies
2. **Formal assessment of**
   - Trauma exposure
   - Trauma- and PTSD symptoms
   - PTSD diagnosis

Introduction: Assessment

- Can the assessment of trauma be psychologically dangerous to the individual?
- Are there risks for the individual (short-term or long-term risks) if he/she is participating in research that is assessing trauma?
- Do people get benefits from recounting of their negative past experiences?

Legerski, John-Paul and Bunnell, Sarah L.(2010) 'The Risks, Benefits, and Ethics of Trauma-Focused Research Participation', Ethics & Behavior, 20: 6, 429 — 442

Don’t Underestimate…

- The idea that the emotional distress from thinking about or talking about the traumatic event makes it even worse, is often underestimating the significance of the traumatic event
- Emotional reaction during assessment is not the same as re-traumatization

How to Assess Traumatic Experiences

- Formal assessment versus informal assessment
- ‘Talking’ about traumatic experiences
- Asking the client directly about traumatic experiences or not?
- How do I prepare talking about traumatic experiences together with the client?
- What if I trigger something, or remind the client of something she has not thought about for a long time and tried to forget?

Measures of Trauma Exposure

→ **NOT the same as PTSD symptoms or diagnosis!**

- Traumatic Stress Schedule (TSS)
- Traumatic Events Questionnaire (TEQ)
- Trauma History Questionnaire (THQ)
- Stressful Life Events Screening Questionnaire (SLESQ)
- Traumatic Life Events questionnaire (TLEQ)
- The Life Stressor Checklist (LSC)

Measures of Trauma Exposure

- The Brief Trauma Questionnaire (BTQ)
- Potentially Stressful Events Interview (PSEI)
- Evaluation of Lifetime Stressors (ELS)
- Childhood Trauma Questionnaire – Short Form (CTQ-SF)
- Childhood Traumatic Events Scale (CTES)
- … many more …

Example: SLESQ

APPENDIX: Stressful Life Events Screening Questionnaire

The items listed below refer to events that may have taken place at *any point in your entire life*, including early childhood. **If an event or ongoing situation occurred more than once, please record all pertinent information about additional events on the last page of this questionnaire.** *Please print or write neatly.*

1. Have you ever had a life-threatening illness?

No _____ Yes _____ If yes, at what age? _____

Duration of Illness (in months) _____

Describe specific illness _____

2. Were you ever in a life-threatening accident?

No _____ Yes _____ If yes, at what age? _____

Describe accident _____

Did anyone die? ____ Who? (relationship to you) _____

What physical injuries did you receive? _____

Were you hospitalized overnight? No _____ Yes _____

3. Was physical force or a weapon ever used against you in a robbery or mugging?

No _____ Yes _____ If yes, at what age? _____

How many perpetrators? _____

Describe physical force (e.g., restrained, shoved) or weapon used against you.

_____

Did anyone die? _____ Who? _____

What injuries did you receive? _____

Was your life in danger? _____

4. Has an immediate family member, romantic partner or *very close* friend died as a result of accident, homicide, or suicide?

No _____ Yes _____ If yes, how old were you? _____

Example: CTES

Childhood Traumatic Events Scale

For the following questions, answer each item that is relevant. Be as honest as you can. Each question refers to any event that you may have experienced **prior to the age of 17**.

1. Prior to the age of 17, did you experience a death of a very close friend or family member?_____ If yes, how old were you?_____

   If yes, how traumatic was this? (using a 7-point scale, where 1 = not at all traumatic, 4 = somewhat traumatic, 7 = extremely traumatic)_____

   If yes, how much did you confide in others about this traumatic experience at the time? (1 = not at all, 7 = a great deal)_____

2. Prior to the age of 17, was there a major upheaval between your parents (such as divorce, separation)?_____ If yes, how old were you?_____

   If yes, how traumatic was this? (where 7 = extremely traumatic)_____

   If yes, how much did you confide in others? (7 = a great deal)_____

3. Prior to the age of 17, did you have a traumatic sexual experience (raped, molested, etc.)?_____ If yes, how old were you?_____

   If yes, how traumatic was this? (7 = extremely traumatic)_____

   If yes, how much did you confide in others? (7 = a great deal)_____

4. Prior to the age of 17, were you the victim of violence (child abuse, mugged or assaulted -- other than sexual)?_____ If yes, how old were you?_____

   If yes, how traumatic was this? (7 = extremely traumatic)_____

   If yes, how much did you confide in others? (7 = a great deal)_____

5. Prior to the age of 17, were you extremely ill or injured?_____ If yes, how old were you?_____

   If yes, how traumatic was this? (7 = extremely traumatic)_____

   If yes, how much did you confide in others? (7 = a great deal)_____

Example: CTQ-SF

When I was growing up...	Never True	Rarely True	Sometimes True	Often True	Very Often True
1. I didn't have enough to eat.					
2. I knew that there was someone to take care of me and protect me.					
3. People in my family called me things like "stupid," "lazy," or "ugly".					
4. My parents were too drunk or high to take care of the family.					
5. There was someone in my family who helped me feel that I was important or special.					
6. I had to wear dirty clothes.					
7. I felt loved.					
8. I thought that my parents wished I had never been born					
9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.					
10. There was nothing I wanted to change about my family					
11. People in my family hit me so hard that it left me with bruises or marks.					
12. I was punished with a belt, a board, a cord, or some other hard object.					

Self reports of trauma history and symptoms

- The Davidson Trauma Scale (DTS)
- The Impact of Event Scale - Revised (IES-R)
- National Women's Study PTSD Module
- Minnesota Multiphasic Personality Inventory (MMPI: PTSD Subscale)
- The Post Traumatic Stress Disorder Symptom Scale– Self Report (PSS-SR)
- Posttraumatic Stress Diagnostic Scale (PSDS)
- Posttraumatic Symptom Scale (PSS)

Self reports of trauma history and symptoms

- The PTSD Checklist (PTSD-CL)
- The PTSD Interview
- Self-Rating Scale for PTSD
- Symptom Checklist-90 (SCL-90; PTSD Subscale)
- The Trauma Symptom Checklist-40 (TSC-40)
- The Trauma Symptom Inventory (TSI)
- Posttraumatic Symptom Scale (PSS)
- … many more …

Example: TSC-40

Trauma Symptom Checklist – 40

(Briere & Runtz, 1989)

How often have you experienced each of the following in the last month? Please circle one number, 0-3.

Symptom	Never - - - - - - - - - - - Often			
	0	1	2	3
1. Headaches				
2. Insomnia				
3. Weight loss (without dieting)				
4. Stomach problems				
5. Sexual problems				
6. Feeling isolated from others				
7. "Flashbacks" (sudden, vivid, distracting memories)				
8. Restless sleep				
9. Low sex drive				
10. Anxiety attacks				
11. Sexual overactivity				
12. Loneliness				
13. Nightmares				
14. "Spacing out" (going away in your mind)				
15. Sadness				
16. Dizziness				
17. Not feeling satisfied with your sex life				
18. Trouble controlling your temper				
19. Waking up early in the morning				
20. Uncontrollable crying				

Example: PSS

PTSD Symptom Scale (PSS)

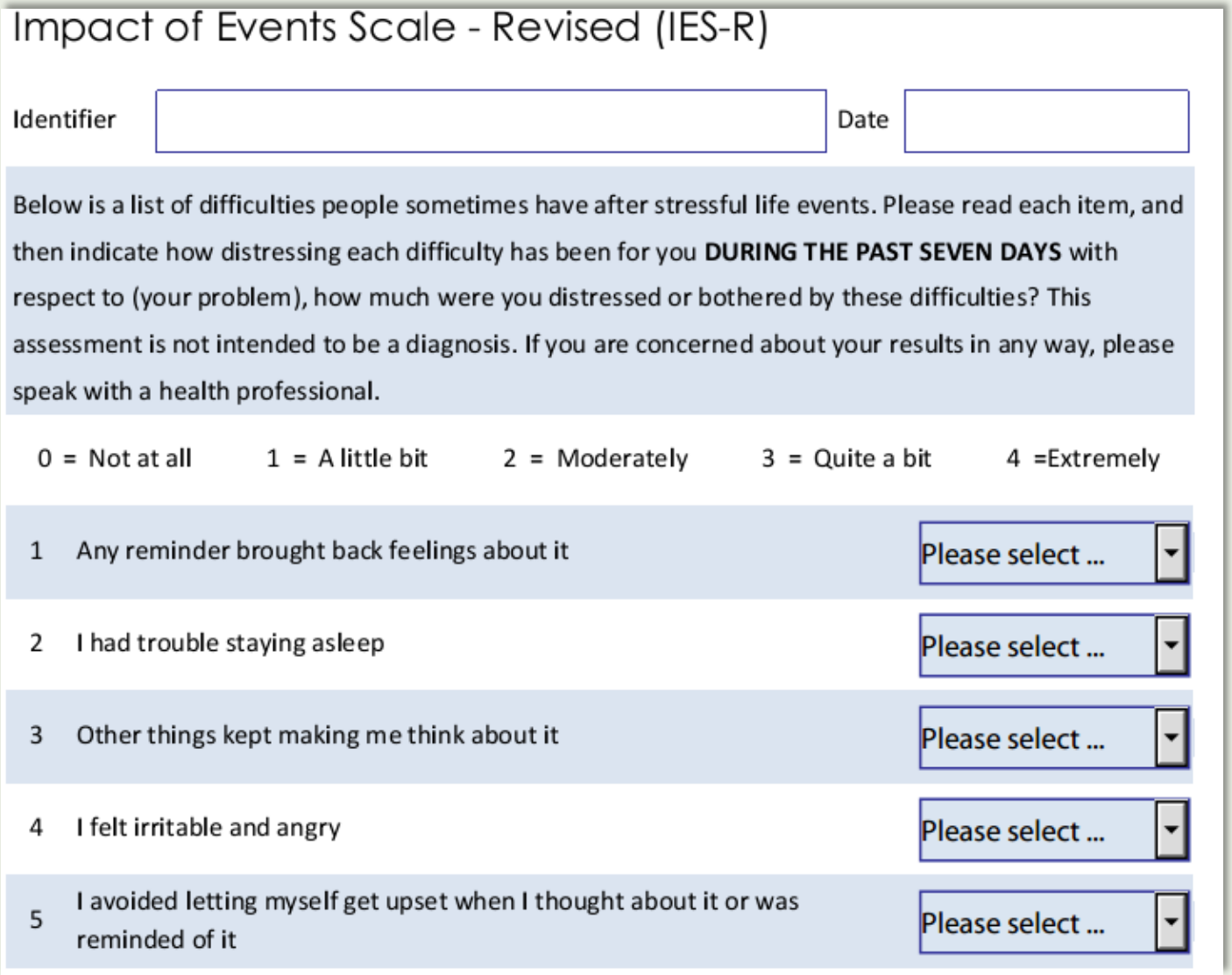
(Side 2)

Below is a list of problems that people sometimes have after experiencing a traumatic event. Please rate on a scale from 0-3 how much or how often these following things have occurred to you:

0 Not at all
1 Once per week or less/ a little bit/ one in a while
2 2 to 4 times per week/ somewhat/ half the time
3 3 to 5 or more times per week/ very much/ almost always

1. Having upsetting thought or images about the traumatic event that come into your head when you did not want them to	0	1	2	3
2. Having bad dreams or nightmares about the traumatic event	0	1	2	3
3. Reliving the traumatic event (acting as if it were happening again)	0	1	2	3
4. Feeling emotionally upset when you are reminded of the traumatic event	0	1	2	3
5. Experiencing physical reactions when reminded of the traumatic event (sweating, increased heart rate)	0	1	2	3
6. Trying not to think or talk about the traumatic event	0	1	2	3
7. Trying to avoid activities or people that remind you of the traumatic event	0	1	2	3
8. Not being able to remember an important part of the traumatic event	0	1	2	3
9. Having much less interest or participating much less often in important activities	0	1	2	3
10. Feeling distant or cut off from the people around you	0	1	2	3
11. Feeling emotionally numb (unable to cry or have loving feelings)	0	1	2	3
12. Feeling as if your future hopes or plans will not come true	0	1	2	3
13. Having trouble falling or staying asleep	0	1	2	3
14. Feeling irritable of having fits or anger	0	1	2	3
15. Having trouble concentrating	0	1	2	3
16. Being overly alert	0	1	2	3
17. Being jumpy or easily startled	0	1	2	3

Example: IES-R



Impact of Events Scale - Revised (IES-R)

Identifier

Date

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 SEVEN DAYS** with respect to (your problem), how much were you distressed or bothered by these difficulties? This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a health professional.

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 =Extremely

1	Any reminder brought back feelings about it	Please select ...
2	I had trouble staying asleep	Please select ...
3	Other things kept making me think about it	Please select ...
4	I felt irritable and angry	Please select ...
5	I avoided letting myself get upset when I thought about it or was reminded of it	Please select ...

Assessments for establishing PTSD Diagnosis

→ **DSM-based structured clinical interviews, e.g.:**

- Structured Clinical Interview for DSM-IV (SCID-I)
- MINI-Plus Neuropsychiatric Interview (MINI-Plus)
- Composite International Diagnostic Interview (CIDI)
- Clinician Administered PTSD Scale (CAPS)
- Anxiety Disorder Interview Schedule (ADIS)
- Structured Interview for PTSD (SIP)

Assessments for establishing PTSD Diagnosis

→ **Assessment of DSM PTSD diagnostic criteria, i.e.:**

- History of traumatic event, and intense emotional response
- The traumatic event is persistently re-experienced
- Avoidance of trauma-related stimuli, numbing of emotions
- Increased arousal

Example: MINI-Plus

J. POSTTRAUMATIC STRESS DISORDER

(→MEANS: MOVE TO THE NEXT MODULE)

J1	Have you **ever** experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else?	→ NO	YES

EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERROIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, SUDDEN DEATH OF SOMEONE CLOSE TO YOU, WAR, OR NATURAL DISASTER.

J2	Did you respond with intense fear, helplessness or horror?	→ NO	YES
J3	During the **past month**, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions)?	→ NO	YES

Example: CAPS

Criterion B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. (B-1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

Frequency	***Intensity***	***Past week***
Have you ever had unwanted memories of (EVENT)? What were they like? *(What did you remember?)* [IF NOT CLEAR:] *(Did they ever occur while you were awake, or only in dreams?)* [EXCLUDE IF MEMORIES OCCURRED ONLY DURING DREAMS] **How often have you had these memories in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How much distress or discomfort did these memories cause you? Were you able to put them out of your mind and think about something else?** *(How hard did you have to try?)* **How much did they interfere with your life?** 0 None 1 Mild, minimal distress or disruption of activities 2 Moderate, distress clearly present but still manageable, some disruption of activities 3 Severe, considerable distress, difficulty dismissing memories, marked disruption of activities 4 Extreme, incapacitating distress, cannot dismiss memories, unable to continue activities ***QV (specify)*** _____	***F*** _____ ***I*** _____ ***Past month*** ***F*** _____ ***I*** _____ ***Sx: Y N*** ***Lifetime*** ***F*** _____ ***I*** _____ ***Sx: Y N***

Example: ADIS

Post Traumatic Stress Disorder

(Do you remember any extremely stressful, life threatening, or traumatic event such as serious physical injury, rape, assault or combat which happened to you prior to your experiencing anxiety or the other problems you're having?)

YES NO

If NO, skip to Agoraphobia.
If YES, (What was the event?)

_____

(When?)_____

(After it happened, did you experience such things as:) (When did you experience these?) Note under *past* or *current*.

1. Re-experiencing event: (Having recurrent memories or dreams about it?)

CURRENT	*PAST*	*ONE SYMPTOM REQUIRED FOR DIAGNOSIS*
_____	_____	(a) Recurrent and instrusive recollections
_____	_____	(b) Recurrent dreams
_____	_____	(c) Sudden acting or feeling as if event is recurring

2. Numbing of responsiveness or reduced involvement (Feeling numb, detached from people?)

CURRENT	*PAST*	*ONE SYMPTOM REQUIRED FOR DIAGNOSIS*
_____	_____	(a) Marked diminished interest in one or more significant activity
_____	_____	(b) Feeling of detachment or estrangement from others
_____	_____	(c) Constricted affect

3. Experiencing such things as (that were *not* present before trauma:)
(Noticed changes like:)

CURRENT	*PAST*	*TWO SYMPTOMS REQUIRED FOR DIAGNOSIS*
_____	_____	(a) Hyperalert, exaggerated startle
_____	_____	(b) Sleep disturbance
_____	_____	(c) Guilt about survival, or behavior for survival
_____	_____	(d) Memory impairment, trouble concentrating
_____	_____	(e) Avoiding activities which remind you of the event
_____	_____	(f) Intensification of symptoms by events which symbolize or resemble event

4. (Are you still experiencing some of these problems?)
If NO, (When did they end?)

_____

If YES, (Which ones?) Check off symptoms above under CURRENT. Note time period symptoms occurred.

_____

_____

_____

DIAGNOSIS requires 'YES' to branching question above plus one symptom from Group 1 and Group 2, and two symptoms from Group 3.

ACUTE = onset within 6 months of stressor and duration less than 6 months
CHRONIC or DELAYED = duration of 6 months or more and/or onset of symptoms at least 6 months after trauma

Examples how it can work

- Formal assessment: Reading it to the client or letting her read it?
- Giving plenty of heads up; NO surprises
- Giving plenty of options to leave the topic
- Giving options how to leave the topic without completely leaving the situation (not letting the client get so irritated that she has to panic and run away)
- Breaks
- Client drives the process

Before – During - After

➔ **Before the assessment**

- Heads up!
- No surprises
- Preparation, develop a plan in case it gets bad

➔ **During the assessment**

- Checking in all the time
- Clients drives process but…
- Interviewer/Clinician has responsibility about the process, too

➔ **After the assessment**

- Checking in
- Winding down/Closing up/Grounding

How do you do it?

→ **Examples:** What worked well or did not work well when assessing or talking with clients about traumatic experiences?

Discussion: Assessment

- Can the assessment of trauma be psychologically dangerous to the individual?
- Are there risks for the individual (short-term or long-term risks) if he/she is participating in research that is assessing trauma?
- Do people get benefits from recounting of their negative past experiences?

Legerski, John-Paul and Bunnell, Sarah L.(2010) 'The Risks, Benefits, and Ethics of Trauma-Focused Research Participation', Ethics & Behavior, 20: 6, 429 — 442

SESSION 3

Intervention/Treatment

Today`s Agenda

1. **Treatment approaches for individuals with concurrent substance use and trauma**
   - Pharmacotherapies
   - Exposure based treatment for PTSD
   - Integrated treatment programs
   - Example: Seeking Safety
   - Effectiveness of integrated interventions
2. **General trauma informed practices**
   - Intake practices and engagement
   - Empathic listening and responding

PTSD Pharmacotherapy

- The U.S. Food and Drug Administration (FDA) has approved two medications for treating adults with PTSD:
  - Sertraline (trade name - Zoloft)
  - Paroxetine (trade name- Paxil)

- Both of these medications were originally used as antidepressants, but they are also used to treat anxiety and other things. They may help control PTSD symptoms such as sadness, worry and anger.

- Taking these medications may make it easier to go through psychotherapy, which is another important treatment component for PTSD.

PTSD/SUD pharmacology

→ **PTSD**

- Medications such as antidepressants are most commonly used
- Mood stabilizers and antipsychotic also used

→ **SUD**

- Substitution therapy for opiates
- Medications for alcohol dependence
- Self as non-human, evil, or flawed

PTSD/SUD pharmacology

→ **Comorbidity**

- Possibly medications for PTSD don't work as well when individual also has a concurrent substance use disorder – usually PTSD and SUD are treated seperately with pharmacological treatment, no clear suggestion what to do when client has concurrent PTSD/SUD

Current Recommendations for PTSD treatment

Psychological treatment for PTSD: 1st level ratings:

VA/DoD 2004	APA 2004	NICE 2005	NHMRC 2007	ISTSS 2008*	IoM 2007
CT (A) Exposure(A) SIT (A) EMDR (A)	TFCBT (I)	TFCBT (A) EMDR (A)	TFCBT (A) EMDR in add. to in vivo exposure (A)	Exposure(A) CPT (A) CT (A) SIT (A) EMDR (A)	Exposure (including CPT)

Forbes et al. (2010). A Guide to Guidelines for the Treatment of PTSD an Related Conditions. J Traumatic Stress, 23;5:. 537–552.

Exposure therapy

- **In vivo exposure**
  - Develop hierarchy of feared/avoided situations
  - Start exposure with situations eliciting moderate fear
  - Progress up hierarchy when distress sufficiently reduced
- **Imaginal exposure**
  - Recount traumatic experience to therapist or as a written assignment
- **Daily exposure (homework)**
- **To be effective, person should fully expose themselves to the emotional content of their experience**

Ref.:Henslee & Coffey 2010 Resick & Schnike

Integrated Programs for Individuals with concurrent substance abuse and trauma

→ **Components of IT programs**

- Cognitive-behaviourally based
- Stabilization and safety
- Understanding the connections between trauma and substance use
- Motivational interviewing elements
- Skills training
- Social support
- Strategies to cope with negative emotions
- Relapse prevention

NOTE:

Gender-specific components more advanced for women than men

Example: Seeking Safety

Stand-alone treatment, 25 sessions, 50-90 minutes, twice weekly

1. Concurrent substance use disorder (SUD) and trauma/ posttraumatic stress disorder (PTSD)
2. Review of PTSD
3. Detaching from emotional pain (grounding)
4. When substances control you
5. Asking for help
6. Taking good care of yourself
7. Compassion
8. Red and green flag
9. Honesty
10. Recovery thinking
11. Integrating the split self
12. Commitment
13. Creating meaning
14. Community resources
15. Setting boundaries in relationships
16. Discovery
17. Getting others to support your recovery
18. Coping with triggers
19. Respecting your time
20. Healthy relationships
21. Self-nurturing
22. Healing from anger
23. The life choices game (review)
24. Termination

Seeking Safety

- The Treatment Program ‘Seeking Safety’ has 5 principles – 2 of them coming up as examples
- Several other IT programs exist that are based on similar ideas
- The following two principles are very general, but we would like to invite you to discuss and speak about examples from your own experience in your work

Principle 1: Safety is the First Priority of Treatment

- → **Establishing safety is a priority in treating both issues**
- → **Judith Herman's Stages of Healing**
  - Stage 1: Safety
  - Stage 2: Mourning
  - Stage 3: Reconnecting
- → **Safety includes: discontinuing* substance abuse, decreasing suicidality, gaining control over extreme symptoms, stopping* harmful behaviors**
- → **Helps to protect the therapist, too**

*in an ideal world

Principle 5: Attention to the Therapeutic Process

- Building an alliance
- Compassion for patient's experience
- Using various coping skills in one's own life
- Giving patients control whenever possible
- Modeling what it means to try hard
- Obtaining feedback about patients genuine reactions to treatment

IT Control Group studies Targeting Women (Part 1 of 3)

Study	Sample	Interventions	Outcome (at longest FU)
Hien et al. (2004)	115 women with SUD-PTSD	Seeking Safety vs. Relapse prevention vs. Standard Community Care	SS improved SUD and PTSD symptoms; SS = RP; SS & RP > SCC
Hien et al. (2009)	353 women with SUD-PTSD	Seeking Safety vs. Women's Health Education	SS improved PTSD but not SUD symptoms; SS = WHE
Morrissey et al. (2005)	2729 women with trauma history, SUD and MHD	IT (varying by site) vs. SUD treatment	IT improved PTSD but not SUD symptoms; IT > SUD treatment (for PTSD)
Najavits et al. (2006)	33 adolescent girls with SUD-PTSD	Seeking Safety vs. no intervention	SS improved some PTSD and SUD symptoms; SS > CG for some symptoms

IT Control Group studies Targeting Women (Part 2 of 3)

Study	Sample	Interventions	Outcome (at longest FU)
Zlotnick et al. (2009)	49 incarcerated women with SUD-PTSD	Seeking Safety vs. 12-step based SUD treatment	SS improved SUD and PTSD symptoms; SS = 12-steps
Desai et al. (2008)	91 homeless female veterans with psychiatric or SUD problems	Seeking Safety vs. no intervention (within Homeless Female Veteran Program)	SS improved SUD and PTSD symptoms; SS > CG for some PTSD symptoms, but SS < CG for drug use
Covington et al. (2008)	200 women with SUD and trauma or mental health issues	Helping Women Recover, followed by Beyond Trauma	HWR + BT improved trauma and SUD symptoms

IT Control Group studies Targeting Women (Part 3 of 3)

Study	Sample	Interventions	Outcome (at longest FU)
Najavits et al. (1998)	27 women with SUD-PTSD	Seeking Safety	SS improved SUD and PTSD symptoms
Weller et al. (2005)	6 female veterans with SUD and trauma history	Seeking Safety	SS improved SUD but not PTSD symptoms
Zlotnick et al. (2003)	18 incarcerated women with SUD-PTSD	Seeking Safety vs. 12-step based SUD treatment	SS improved SUD and PTSD symptoms

Summary of IT Outcome Studies

- IT effectively reduced PTSD and SUD symptoms from baseline through follow-up.
- IT and non-IT conditions produced similar reductions in PTSD and SUD symptoms.
- Women-specific issues addressed in some treatments included: female therapists, family strengthening, family reunification, parenting, empowerment, discussing sexual abuse, stigma, domestic violence.

Therapy for PTSD – Resources for British Columbia

- **BC Crime Victim Assistance Program:**
  www.pssg.gov.bc.ca/victimservices/financial/index.htm
  - Approx. 5 months wait
  - 1 year of counselling
  - Other services: financial support for children and disability
- **Victim Link BC:**
  http://www.victimlinkbc.ca/
  - Support for obtaining victim services
- **Residential Historical Abuse Program 1-604-730-0188**
- **Women Against Violence Against Women (WAVAW):**
  www.wavaw.ca 1-877-392-7583
  - 10 month waitlist
- **BC Society for Male Survivors of Sexual Abuse:**
  http://bc-malesurvivors.com/

TIP

- TIP - Trauma informed principles
- Trauma-informed versus trauma-specific
- TIP-Principles
- TIP-Ideas on specific situations

What is it? Trauma informed & Trauma specific

→ Trauma Informed Services

- Are informed about trauma, and work at the client, staff, agency and system levels from the core principles of trauma awareness, safety and trustworthiness, choice and collaboration, and building of strength and skills

- The connections between trauma, mental health substance use are discussed in the course of work with all clients, trauma symptoms/ adaptations are identified, and supports and strategies offered that increase safety and support connection to services.

→ Trauma Specific Services

- Are offered in a trauma informed environment, and are focused on treating trauma through therapeutic interventions involving practitioners with specialist skills.

- Offer services to clients with trauma, mental health, and substance use concerns who seek and consent to integrated treatment, based on detailed assessment.

BC TIP Guide, 2013

TIP: Trauma-informed practices

2011 focus groups of BC addictions and mental Health providers

→ **TIP – Trauma informed intake practices:**

- Create safety (including cultural safety)
- Engage – establish a therapeutic relationship
- Do not "press for compliance"
- Screen for present concerns
- Normalize client experience(s)
- Set boundaries
- Strategies to cope with negative emotions
- Identify symptoms

Please share your experiences!

TIP PRINCIPLE

#1

Emphasis on Safety & Trustworthiness

Please share your experiences!

➔ **Trauma Survivors:**

- Likely have experienced boundary violations and abuse of power
- Need to feel physical and emotionally safe
- May currently be in unsafe relationships

➔ **Safety and trustworthiness are established through:**

- welcoming intake procedures
- adapting the physical space
- providing clear information and predictable expectations about programming
- ensuring informed consent
- creating crisis plans . . .

TIP PRINCIPLE

#2

Engagement of Clients

(& avoiding re-traumatization)

Please share your experiences!

➔ **Promote safety and trustworthiness by:**

- Acknowledging and attending to immediate needs
- Being transparent, consistent & predictable
- Being clear about role and boundaries
- Explaining confidentiality (including limits)
- Obtaining informed consent
- Asking what works if feeling upset or anxious – how do they want you/program to support them if this happens?

TIP PRINCIPLE
#3

Opportunity for choice, collaboration & connection

Please share your experiences!

➔ **Create safe environments that foster a client's sense of efficacy, self-determination, dignity, and personal control.**

➔ **Service providers are encouraged to:**

- communicate openly
- equalize power imbalances
- allow the expression of feelings without fear of judgment
- provide choices as to treatment preferences, and
- work collaboratively

Tip-Ideas on 'Making Contact with the Client'

➔ **Promote collaboration & choice by:**

- Asking how would they like to be contacted
- Are they comfortable working with female/male?
- Asking if there is anything that might prevent their participation – work together to problem solve

➔ **Sample phrases:**

- *"what is most important for you that we should start with?"*
- *"it is important to have your feedback every step of the way"*
- *"this may or may not work for you – you'll know best"*
- *"you can choose to pass on any question"*

TIP-ideas on Responding to trauma disclosure

- **Acknowledge and express empathy:** *"I appreciate your honesty"*
- **Offer a larger context for the trauma** - not alone
- **Validate:** *"I appreciate your courage to share"*
- **Address time** – being respectful of person's story and supporting containment: *"This is very important, we only have 10 minutes, so I wonder about dedicating time in next apt"*
- **Offer hope:** *"This will help with their care and healing"*
- **Work together to create a self-care plan for after they leave:** *"People respond differently to talking about upsetting memories, I encourage you to check-in with yourself and notice how you are feeling after you leave"*

TIP-ideas on Responding to trauma disclosure

"I don't know why I respond like that…it's like I lose my mind."

Practitioner: *"Given everything that you have described, it sounds like a pretty normal response to abnormal events."*

"I feel like such a failure. Here I am back in the hospital again."

Practitioner: *"No matter how bad things get, you don't give up. You know what you need to do to keep yourself safe."*

"I don't know why I freak out like that when my partner is late. I hate myself afterwards."

Practitioner: ***"Based on what you have described, your childhood experiences of never knowing if your parents were going to follow through, it makes sense that it is important to you that people are reliable and dependable. You are doing the best you can, based on what you know, and trying to communicate this with others…(pause)… I wonder if you'd be interested in looking at some other options for how you might express this to your partner and others."***

TIP: IDEAS on Working with People Who Identify as Aboriginal

- → **Recognize diversity (learn about background, history, identity & culture)**
- → **Provide opportunities for longer engagement process given history of oppressive policies**
- → **Be prepared to offer clients a larger social context for problems – link to colonial history**
- → **Partner with cultural helpers/cultural teachers**
- → **Be open to [Aboriginal] traditional or complementary healing practices**

Menzies, 2012

TIP: Examples on Trauma Awareness

- → Acknowledge common, connections between substance use and trauma
- → Recognize range of responses people can have
- → Recognize that because of trauma responses, developing trusting relationships can be difficult
- → Disclosure of trauma is not required
- → Recognize when someone is triggered or experiencing the effects of trauma & support

BC TIP Guide, 2013; Gender Matters,2013

TIP: IDEAS and Examples Physical Environment

- → Signage with welcoming messages and avoid rule based language; with “do not” messages
- → Making waiting areas comfortable and inviting
- → Lighting in outside spaces
- → Accessibility and safety of washrooms
- → In counseling rooms – choice about whether door is open or closed

Fallot & Harris, 2009, &Ontario Guidelines, 2013

TIP: Ideas In Counselling Work

➔ **Maximize – as an ongoing (therapeutic) process:**

- consistency
- follow through - if you say you will do something
- honesty and transparency

➔ **Consider:**

- avoiding unnecessary disappointment
- whether people are fully informed of risks during consenting & have choice for partial consent or withholding consent

Guarino et al. 2003; Fallot & Harris, 2009; Gender Matters, 2013

TIP: Can be seen in a change in the way we view people

Shift from: “What is wrong with her” to “What happened to her”

→ **Change in language away from:**

- Controlling
- Paranoid
- Manipulative
- Uncooperative
- Untreatable
- Masochistic
- Attention seeking
- Drug seeking
- Bad mother
- Not believable, etc.

Williams & Paul, 2008

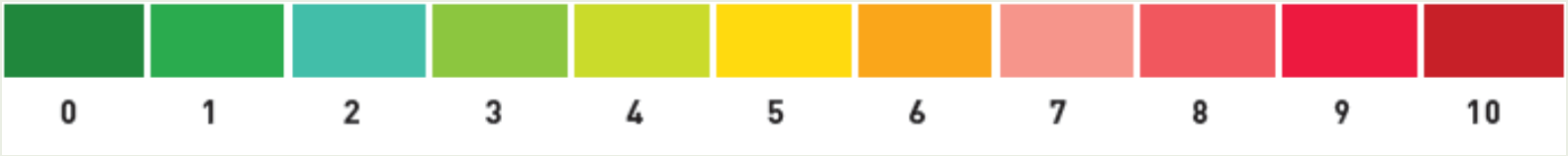
SESSION 4-6 (or more if needed)

Practice Sessions

Today's Agenda

1. **Therapeutic techniques to cope with trauma symptoms**
   - Distress rating scale
   - Breathing and progressive muscle relaxation exercises
   - Practice in small groups
   - Discussion of experiences

Distress Rating



Zero represents no distress at all.

Ten represents something that bothers you as bad as you can imagine.

Example Breathing Exercise

➔ **There are many different breathing exercises out there – this is an example. Share yours!**

- ‘Put a hand on your stomach area, just below your belly button. Feel how your hand rise up every time you inhale… and fall about an inch every time you exhale. [Pause]. Relax your belly….more and more with each breath….feel your hand on your belly….[Pause]. Breathe……Feel the air entering and leaving your body……allow yourself to sigh out loud ….breathe…..[Pause]….breathe…..’

Example Muscle Relaxation

→ **There are many forms of muscle relaxation out there, one of the common ones is 'progressive musclerelaxation' based on tensing and then relaxing a muscle (group). Share your examples!**

- E.g. 'Now clench your left hand into a tight fist; feel the tension in the muscles of your hand and lower left arm. Hold it (5 seconds). And then release the tension (5 seconds). Let your hand and fingers relax and experience the transition from tension to relaxation (5 seconds)'

Grounding

- Tool to deal with negative emotions, pain and emotional distress
- Is an active and intentional effort to take your attention away from the distress and focus it on external, physical or mental stimuli
- Goal is to reduce the emotional pain so it becomes manageable
- Can be viewed as a variant of mindfulness
- Some call it “centering”, “healthy detachment”or “a safe place”

Grounding

- Some overlap with ‘mindfulness’
- Strategy to deal with overwhelming negative emotions, dissociations, etc.
- Take your attention away from the distress and connect you with the present moment.
- Grounding techniques often use the five senses (sound, touch, smell, taste, and sight).

Grounding

- Form groups of three:
- Instructor, ‘client’/recipient, and observer
- Instructions of a variety of grounding exercises are available
- 20 minutes, then we have a break

Grounding - feedback

- Questions or concerns about grounding?
- What works best for you?
- What would you change?
- In which specific situations could this tool be handy for yourself/with clients?
- How could you become better at grounding? How could you help clients use this technique more frequently and successfully?

Safe Space

- **Self-soothing skill to regulate emotions by ‘travelling’ to an internal safe space**
- **Building on grounding skills (physical) but also including cognitions and emotions**
- **When can you use ‘Safe Space’?**
  - Needs to be practiced
  - Caution: Dissociation
- **Practice is important for both therapist/provider and client**

Safe Space - Practice

- **Practice 1: Facilitator reads an example to the group, after that…**

- **Practice 2: Form groups of three: Instructor, recipient, observer**
  - Handout sheets for Safe Space exercises are available
  - 20 minutes practice
  - Feedback session & Questions

Safe Space – Group Feedback

- How easy/ difficult did you find the exercises?
- What was helpful (not helpful)?
- What happened to your body?
- What happened to your thoughts?
- What happened to your feelings?
- Any other observations or comments?
- What to do if a person cannot imagine a safe space?

Trauma Box

- → Safe box to store distressing memories and thoughts, until the person feels ready to open it (control).
- → Locked and stored away safely – containment!
- → Not forgotten, it is not about avoiding or repressing.
- → Imaginary or real box.

SESSION 7

PTSD and Nightmares

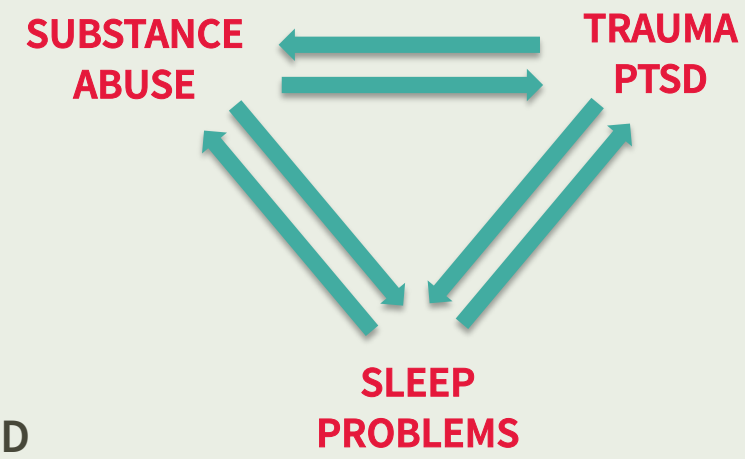
Today`s Agenda

- Substance use, PTSD, and sleep problems
- Nightmares in PTSD
- Treatment approaches for PTSD-related nightmares
- Sleep hygiene

Substance use, PTSD, and sleep problems

➔ What does the research say?

- Substance use/withdrawal may result in sleep problems (including nightmares) (Schierenbeck et al., 2008)
- Sleep problems increase the risk for subsequent alcohol and drug use disorder (Breslau et al., 1996; Crum et al., 2004)
- Trauma exposure and PTSD may result in sleep problems (Babson & Feldner, 2010)
- Sleep problems in individuals with PTSD are associated with drinking alcohol (Nishith et al., 2001)
- Sleep problems may interfere with recovery from PTSD (Babson & Feldner, 2010)



Nightmares

- Nightmares are common among individuals with trauma histories.
- Component of the intrusive/re-experiencing PTSD symptom cluster.
- Distress and daytime impairment (e.g., fatigue, exacerbation of psychological distress, etc.).
- Interference with recovery from trauma/PTSD.
- Improvement of nightmares may contribute to improved well-being and functioning.
- First line psychological and pharmacological interventions for PTSD frequently fail to fully treat insomnia and nightmares.

Maher et al. (2006). Sleep Disturbances in Patients with Post-Traumatic Stress Disorder. CNS Drugs 20;7: 567 ff.

Addressing PTSD Related Nightmares

How do you address nightmares/sleep problems in your clients?

→ **What does the research say?**

1. Aurora et al. (2010). Best practice guide for the treatment of nightmare disorders in adults. JCSM 6; 4: 389 ff.
2. Nappi et al. (2012). Treating nightmares and insomnia in posttraumatic stress disorder: A review of current evidence. Neuropharm 62: 576 ff.
3. Maher et al. (2006). Sleep disturbances in patients with post-traumatic stress disorder. CNS Drugs 20;7: 567 ff.

Treatment of PTSD Related Nightmares

→ **Prazosin (α -adrenergic receptor blocker)**

- Retrospective chart review, small uncontrolled studies, open label trials, and RCTs: reduction of PTSD nightmares and sleep disturbances.
- Only medication with Level A recommendation by the AASM.
- Several RCTs underway to examine its efficacy versus placebo, SSRI, and as an adjunct to SSRI and behavioral treatment.

Treatment of PTSD Related Nightmares

- **Imagery Rehearsal Therapy (IRT), and**
- **(Exposure, Rescripting and Relaxation Therapy, ERRT)**
  - Case studies, uncontrolled studies, and waitlist control trials: Reduction in nightmares and psychiatric distress.
  - Unclear how they work and whether their effects exceed non-specific therapy effects.

Imaginal Rehearsal Therapy

Procedure:

1. Recalling the nightmare;
2. Writing it down;
3. Changing the theme/story line/topic to a more positive one;
4. Rehearsing the rewritten dream scenario;
5. Displace the unwanted content when the dream recurs.
6. 10-20 minutes per day while awake.
7. Implement new sleep schedules and behaviours.
8. Group/individual treatment; 1-6 sessions (2-10 hours).

Exposure, Rescripting, and Relaxation Therapy (ERRT)

3-9 sessions (6-9 hours) group treatment:

1. Nightmare tracking;
2. Psychoeducation about sleep and nightmares;
3. Sleep Hygiene;
4. Exposure to a nightmare (◊ write down in detail, read it aloud, identify trauma themes);
5. Nightmare rescripting (as in IRT);
6. Relaxation techniques.

Sleep Hygiene

- Sleep hygiene is a component of most nightmare treatment programs and the most important treatment component of sleeping disorders in general

- Sleep hygiene means having or learning helpful behaviours that promote good sleep

Sleep Hygiene

Discuss & Share your experiences: What are do's and don't's for good, sound sleep?

- **DO's.....**
- **DON'T's...**

Parents with Trauma Histories

- **Film – 'The Biology of Childhood Hardship'; 2013**
  - Marla Sokolowski of the Canadian Institute for Advanced Research explores how the hardships that some children face, including poverty, poor nutrition or neglect, can lead to biological changes that make them more susceptible to health problems - changes that they may then pass along to their own kids.
  - http://tvo.org/video/192655/marla-sokolowski-biology-childhood-hardship
  - Marla Sokolowski is the Co-Director, Child & Brain Development Program, Canadian Institute for Advanced Research

Parenting & Transgenerational Trauma

The following statements are often made when parenting issues of trauma survivors are discussed. What do you think? Please share your experiences and thoughts!

- → Feelings of shame, guilt, and inadequacy can interfere with parenting.
- → Interaction with a child can trigger a mother's traumatic past.
- → The mothers are at risk of becoming overprotective of their children.
- → At the other extreme, they may be seen as neglectful in order to avoid being 'triggered' (reminded of their own childhood trauma) by interacting with their children
- → Mothers with substance use issues ay have been inadequately nurtured themselves.

Feedback

- → Help us to learn and improve
- → Share your thoughts
- → We are happy to learn what can be improved and what you found helpful

Thank you!

We could not have done it without you!