ST VINCENT'S HEALTH AUSTRALIA

Relief from Trauma

Department of Addiction Medicine

15 December 2022

Project ECHO®

St.Vincent's Hospital, Melbourne Australia

What is trauma?

- Any event where a person's life or safety is at serious risk.
- Trauma is both an event and a particular response to an event.
- PTSD is one type of disorder from trauma

What is PTSD?

Exposure to a trauma defined as extremely threatening or horrific with four symptom clusters;

- Re experiencing phenomena
- Avoidance of reminders of trauma related stimuli
- Hypervigilance
- Numbing

PTSD can be seen as a conditioned fear response with symptoms specifically tied to the traumatic event.

Trauma within DSM

- Acute Stress disorder (less than one month)
- PTSD (duration more than one month)
- Pre school subtype (under age 6)
- Dissociative subtype PTSD (both age groups)
- Persistent complex bereavement
- Adjustment disorder
- Reactive attachment disorder (two subtypes)
- Dissociative disorders

PTSD - DSM 5

DSM-5 criteria

A. Exposure to actual or threatened death, serious injury, or sexual violence	
B. Persistent re-experiencing	One of five
C. Persistent avoidance	One of two
D. Persistent numbing	Two of four
E. Persistent hyperarousal	Two of five
F. Duration of at least 1 month	
G. Clinically significant distress/impairment	

Some types of trauma

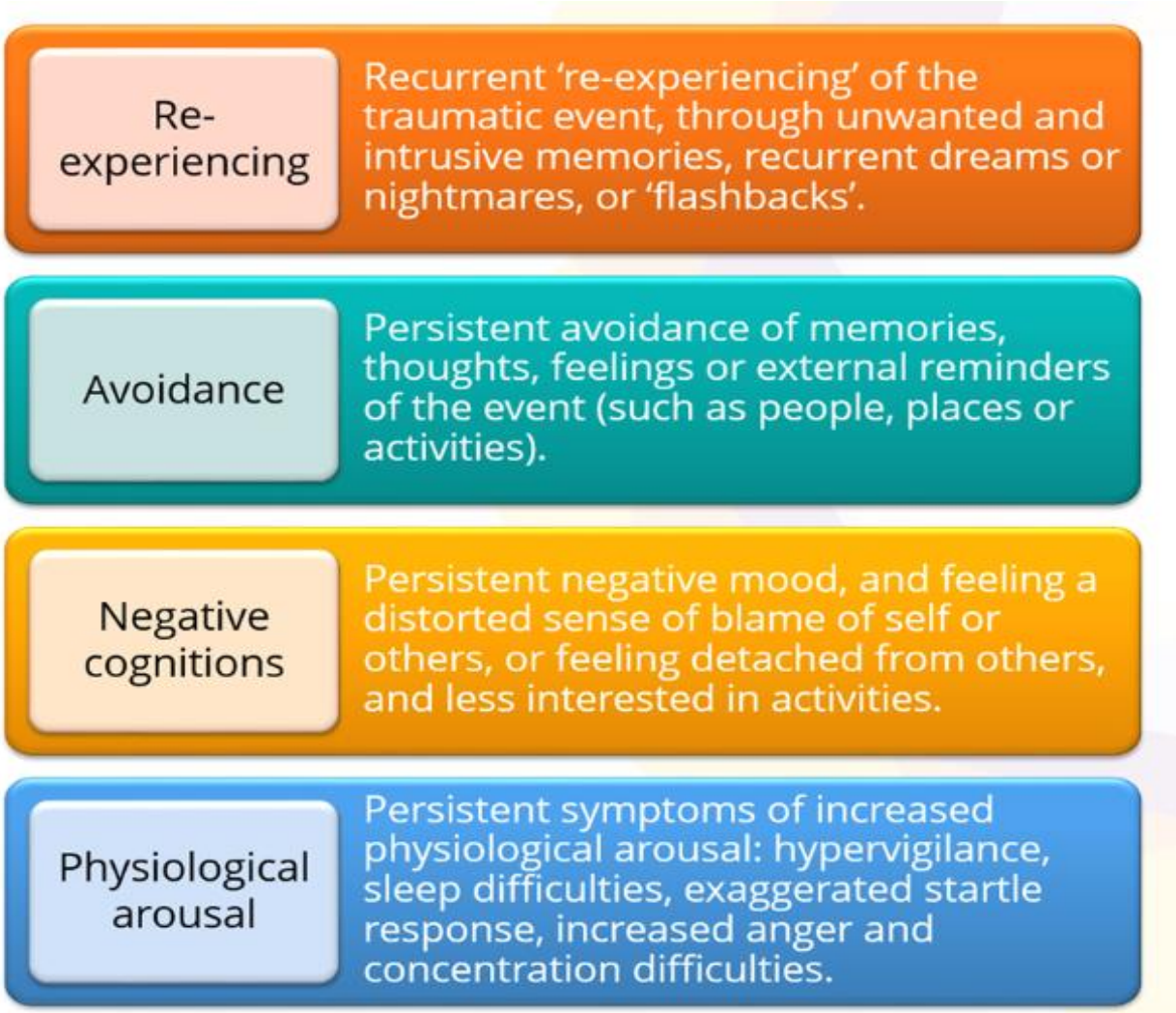
- Developmental
- Sexual abuse
- Bullying
- Family violence
- Violence – exposure to or participation in
- Life threatening traumatic events - experienced and witnessed
- Occupational trauma
- Interpersonal network traumatic experience
- Combat and service
- Physical injury
- Medical illness
- Crime related trauma

Risk factors for developing PTSD

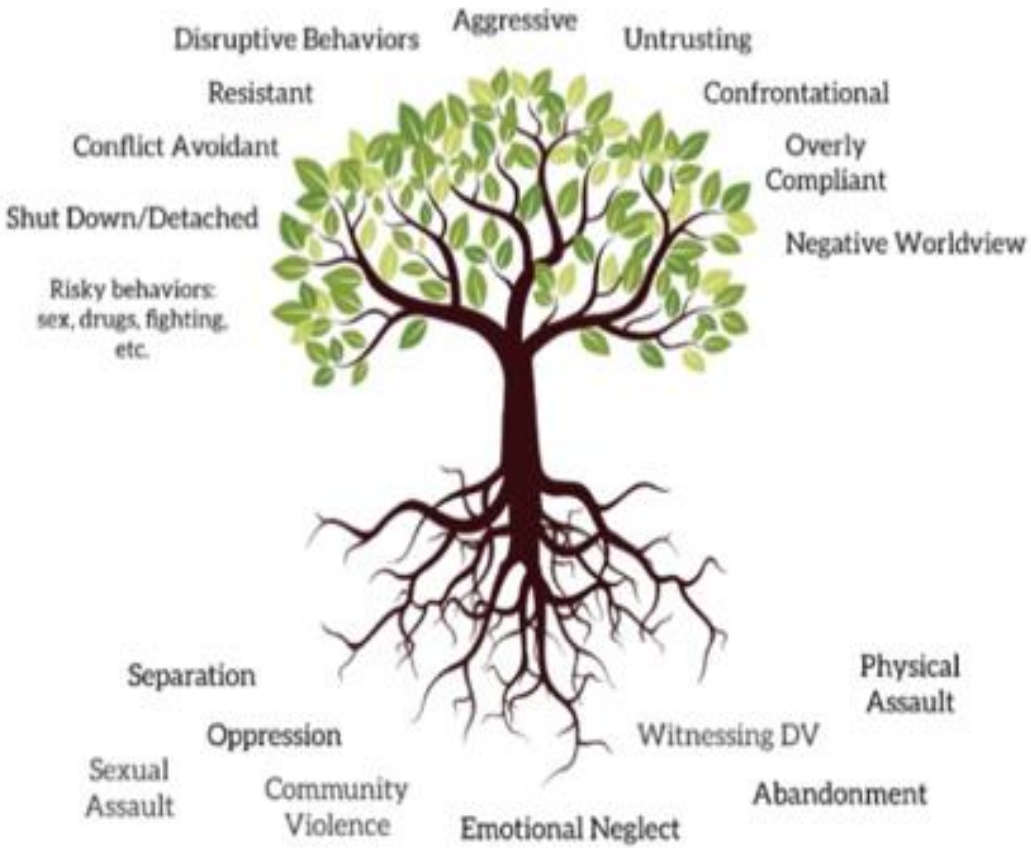
Individual pre trauma risk factors

- Gender, age, race
- Lower education, lower socioeconomic status
- Being separated, divorced or widowed
- Previous trauma
- Childhood adversity
- Personal and family psychiatric history
- Reported childhood abuse
- Poor social support
- Initial severity of reaction to the traumatic event

Effects of trauma

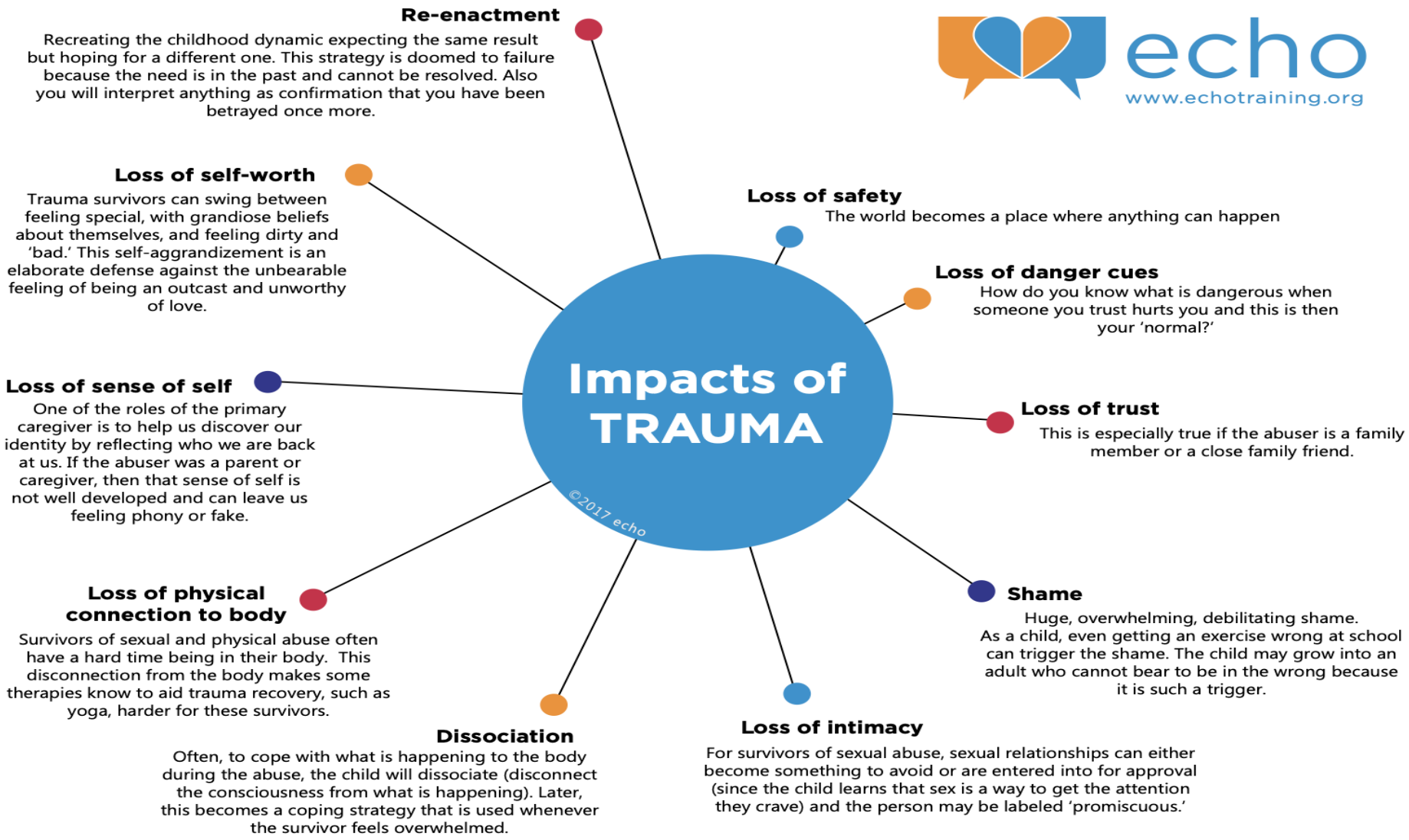


How trauma manifests behaviorally



ST VINCENT'S HEALTH AUSTRALIA

echo
www.echotraining.org



Re-enactment

Recreating the childhood dynamic expecting the same result but hoping for a different one. This strategy is doomed to failure because the need is in the past and cannot be resolved. Also you will interpret anything as confirmation that you have been betrayed once more.

Loss of self-worth

Trauma survivors can swing between feeling special, with grandiose beliefs about themselves, and feeling dirty and 'bad.' This self-aggrandizement is an elaborate defense against the unbearable feeling of being an outcast and unworthy of love.

Loss of safety

The world becomes a place where anything can happen

Loss of danger cues

How do you know what is dangerous when someone you trust hurts you and this is then your 'normal?'

Loss of sense of self

One of the roles of the primary caregiver is to help us discover our identity by reflecting who we are back at us. If the abuser was a parent or caregiver, then that sense of self is not well developed and can leave us feeling phony or fake.

Loss of trust

This is especially true if the abuser is a family member or a close family friend.

Loss of physical connection to body

Survivors of sexual and physical abuse often have a hard time being in their body. This disconnection from the body makes some therapies know to aid trauma recovery, such as yoga, harder for these survivors.

Shame

Huge, overwhelming, debilitating shame. As a child, even getting an exercise wrong at school can trigger the shame. The child may grow into an adult who cannot bear to be in the wrong because it is such a trigger.

Dissociation

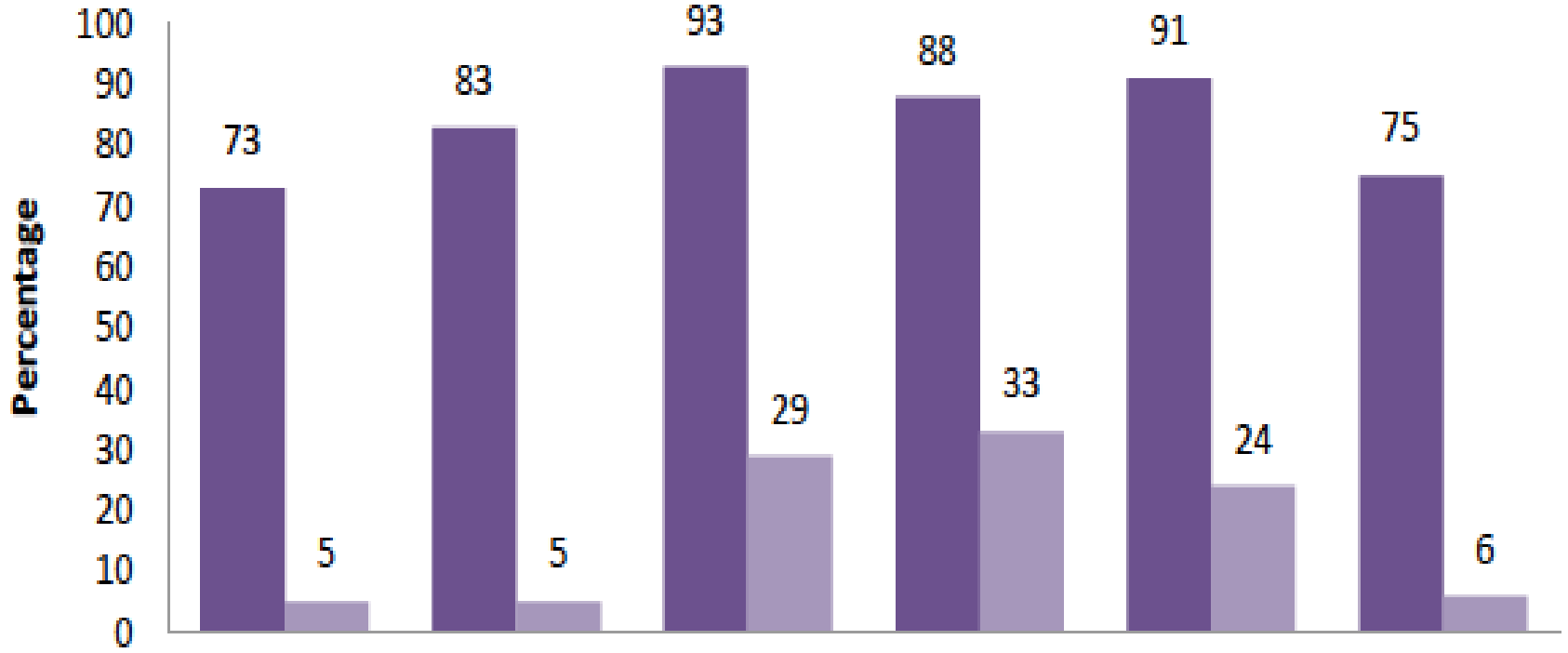
Often, to cope with what is happening to the body during the abuse, the child will dissociate (disconnect the consciousness from what is happening). Later, this becomes a coping strategy that is used whenever the survivor feels overwhelmed.

Loss of intimacy

For survivors of sexual abuse, sexual relationships can either become something to avoid or are entered into for approval (since the child learns that sex is a way to get the attention they crave) and the person may be labeled 'promiscuous.'

Trauma and substance use

Figure 4. The prevalence (%) of trauma exposure and post traumatic stress disorder among Australians with AOD use disorders



Seeking relief in all the wrong places

Opiates – attenuating intense rageful and violent affect.

"In the chronic absence of a sense of wellbeing and an inability to satisfactorily connect to others makes the soothing and comforting actions of opiates and depressants alluringly welcome."

Alcohol – ego solvents

"*narcissistic defenses of disdain and self sufficiency related to poor self esteem which lead to feelings of isolation are lifted with stimulants or low to moderate doses of alcohol and allow connection… for those who resign themselves to withdraw with a sense of injured self ..it is made easier with obliterating doses of alcohol."*

The Self Medication Hypothesis Khantian 1997

Management – providing relief

- How to manage complex patients?
- Scarcity of resources
- AOD and MH systems not well integrated
- Complex health systems difficult to negotiate
- Psychological therapy
  - What sort?
  - When?
  - How long for?

What can I do?


interventions
self-help groups
physical activity
pharmacological
complementary and alternative therapies
psychological

Management – providing relief

Treatment of substance use disorder

Trauma informed integrated care

- trauma awareness
- emphasis on safety and trustworthiness
- opportunity for choice, collaboration and connection
- strengths based and skill building.

Psychological therapy

- What sort?

Psychiatric referral for assessment

- formulation to guide further management
- assessment of risk issues.
- Risk to others – driving, children, forensic issues
- Risk management plan

Principles of trauma informed practice

Safety	**Physical, emotional, environmental, cultural, systematic**
Trustworthiness	**Clarity, consistency, interpersonal, boundaries**
Collaboration	**Maximising client choice & control**
Choice	**Maximising collaboration & sharing power**
Empowerment	**Prioritising empowerment skills**

(Blue Knot Foundation, 2012)

Interventions

- Maintain healthy diet
- Adequate rest
- Regular breaks from using or reduce use
- Grounding techniques, mindfulness, visualisation, breathing exercises
- Exercise – mindful walking, yoga
- Contact with supportive and stable friends, family
- Harm minimisation
- Safety planning
  - Directline
  - CASA, Blue Knot
  - Life Line, MH online services,
  - CAT referral
  - Emergency services
  - Written management plan

Comorbidity Guidelines 2016

Psychological therapies

- trauma focused CBT
  - Exposure therapy
  - Cognitive therapy
- dialectical behaviour therapy
- acceptance and commitment therapy
- mentalisation therapy
- psychodynamic therapy – longer term
- eye movement desensitization and reprocessing (EMDR)

Phoenix Guidelines for adults

Strong recommendation FOR use

Cognitive processing therapy (CPT)

- CPT is a 12-session cognitive-behavioural manualised treatment for PTSD that systematically addresses key post traumatic themes, including safety, trust, power and control, self-esteem, and intimacy.

Cognitive therapy (trauma-focused) (CT)

- Cognitive therapy or CT for PTSD, is a variant of trauma-focused CBT

Eye Movement Desensitisation and Reprocessing (EMDR)

- EMDR is a standardised, eight-phase, trauma-focused therapy involving the use of bilateral physical stimulation (eye movements, taps, or tones).

Prolonged exposure

Trauma-focused CBT

Phoenix Guidelines - Psychological

Interventions for adults with comorbid PTSD and substance use disorder

Conditional recommendation FOR use

Trauma-focused CBT

Concurrent treatment for PTSD and substance use disorder using prolonged exposure (COPE) is an integrated treatment that augments prolonged exposure with cognitive behavioural relapse prevention for substance use.

Non-Trauma-focused CBT

1.Seeking Safety is an integrated non-trauma-focused, present-focused intervention for PTSD and substance use disorder. It consists of 24 modules teaching cognitive behavioural and interpersonal techniques, as well as case management.

2. Integrated CBT focuses on PTSD symptoms and substance use. Designed to be used in routine community addiction treatment programs and consists of 8 modules.

Helping Vulnerable Populations: A Comprehensive Review of the Treatment Outcome Literature on Substance Use Disorder and PTSD

Lisa M. Najavits[1] and Denise Hien[2]

[1] Veterans Affairs Boston Healthcare System / Boston University School of Medicine
[2] City College of New York

- Review of studies for comorbid PTSD and substance use disorder.
- Most models have more effect on PTSD
- Is substance use disorder harder to treat?
- PTSD/SUD treatments generally longer than PTSD alone.
- Present focused.
- Emphasize stabilization and coping.
- Seeking Safety – only treatment outperforming control on PTSD and SUD.

Medication management

- First line – SSRIs sertraline, fluoxetine, paroxetine and venlafaxine.
- Benzodiazepines – ineffective and harmful in treatment of PTSD (Maudsley Guidelines)
- Care with management of arousal symptoms
  - Removing sedating substances can worsen symptoms.
  - SSRIs can worsen sleep issues initially - careful titration.
- Prazosin can be useful in treating nightmares.
  - Increased noradrenergic activity during sleep
  - Dose needs to be titrated carefully over time.
- Over medication can inhibit psychological therapies.

PTSD Pharmacological Prescribing Algorithm

Discuss drug choice with person with PTSD

Include:

- Potential adverse effects (side effects, discontinuation symptoms).
- Potential interactions with concomitant medication or physical illness.
- Individual's perception of the efficacy and tolerability of any SSRIs/SNRIs in the past.

If individual has no contraindicated medical reasons and gives consent, an SSRI should be initiated.

Start SSRI

1st LINE

Fluoxetine

- Initiate on 20mg/day.
- Dosage can be increased by 20mg/day increments at monthly appointments with clinician to a maximum of 60mg/day based on clinical response and tolerability.

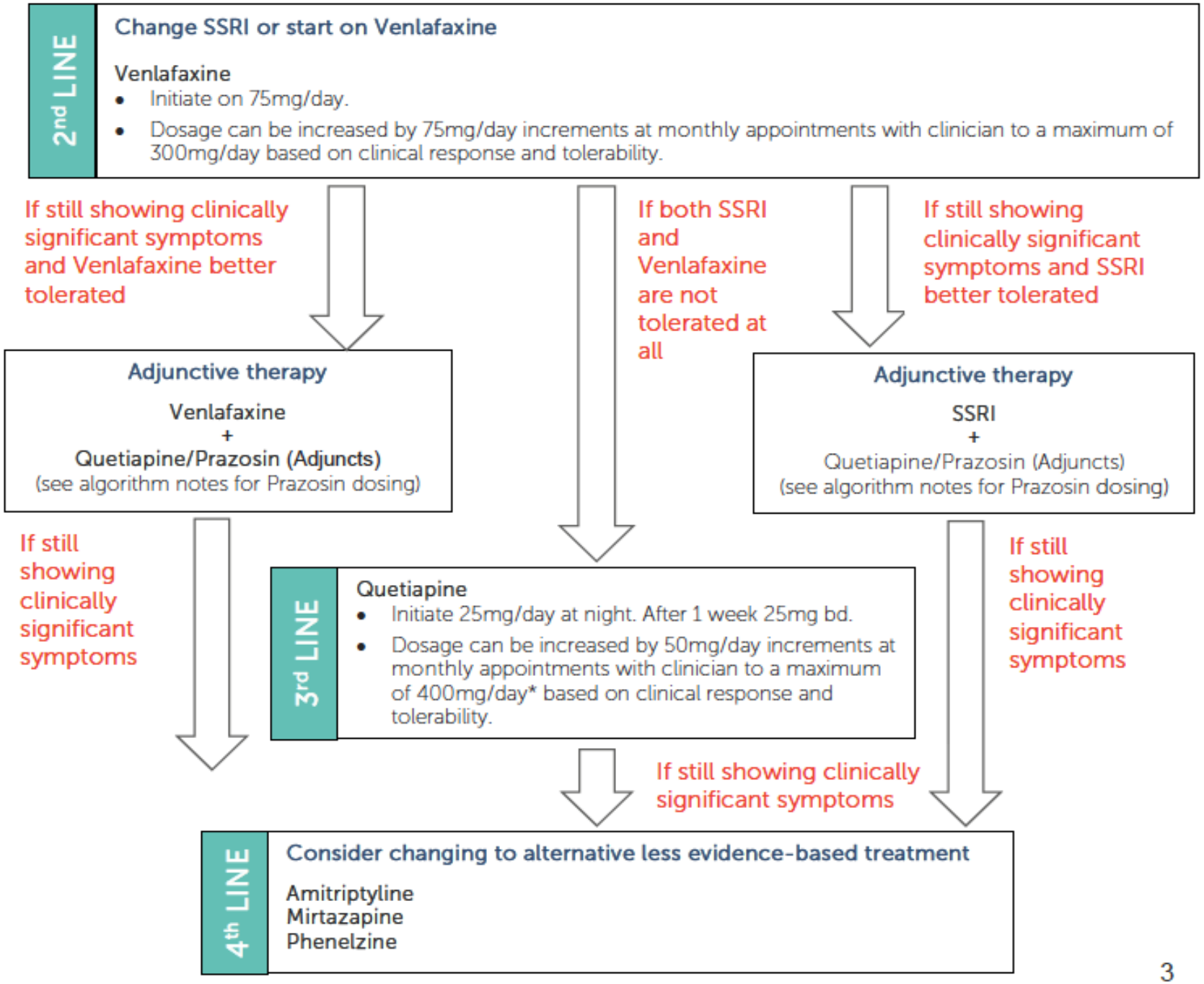
Paroxetine

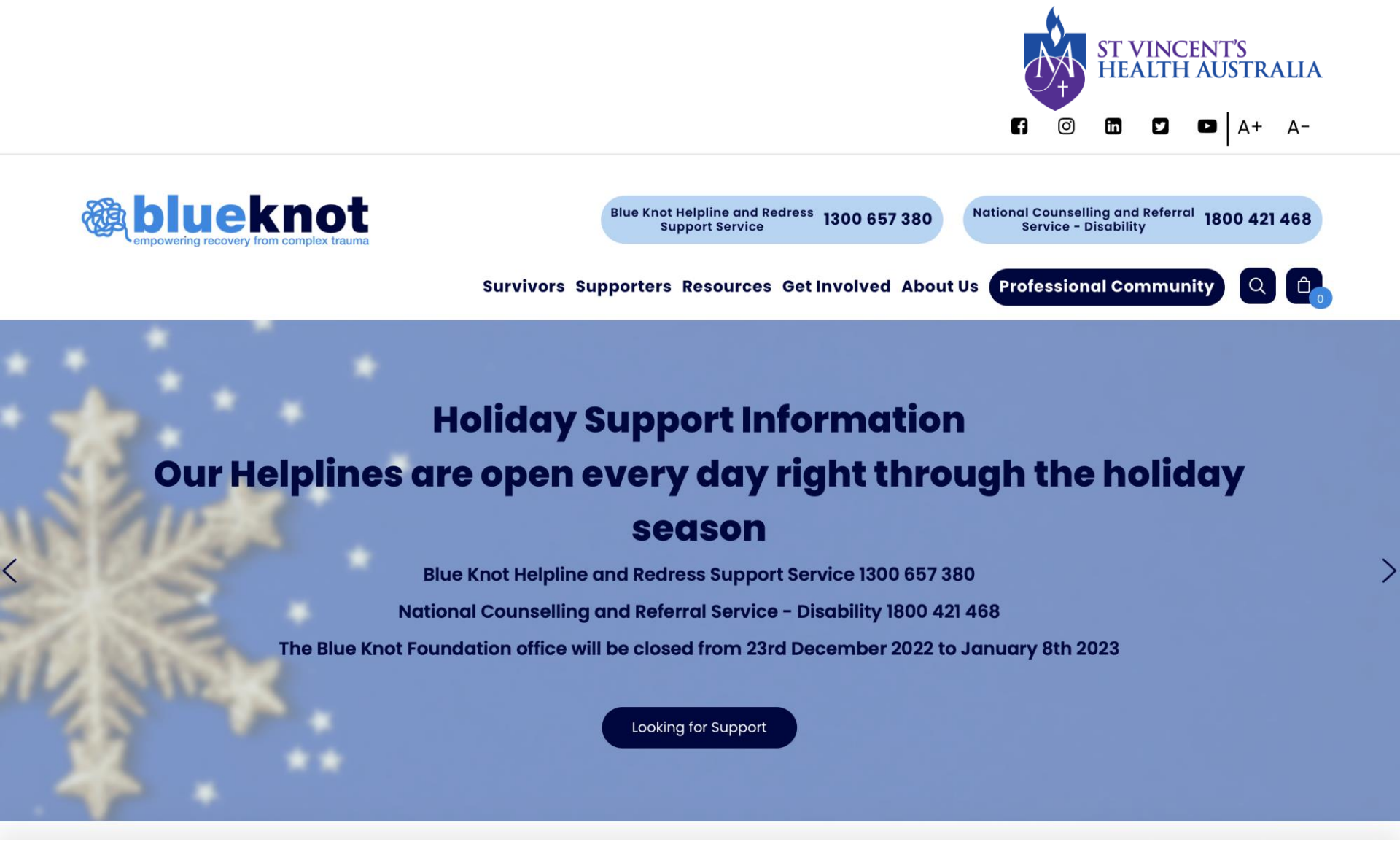
- Initiate on 20mg/day.
- Dosage can be increased by 20mg/day increments at monthly appointments with clinician to a maximum of 60mg/day based on clinical response and tolerability.

Sertraline

- Initiate on 50mg/day.
- Dosage can be increased by 50mg/day increments at monthly appointments with clinician to a maximum of 200mg/day based on clinical response and tolerability.

If SSRI is not tolerated or still showing clinically significant symptoms


2nd LINE
Change SSRI or start on Venlafaxine
Venlafaxine
Initiate on 75mg/day.
Dosage can be increased by 75mg/day increments at monthly appointments with clinician to a maximum of 300mg/day based on clinical response and tolerability.
If still showing clinically significant symptoms and Venlafaxine better tolerated
If both SSRI and Venlafaxine are not tolerated at all
If still showing clinically significant symptoms and SSRI better tolerated
Adjunctive therapy
Venlafaxine
+
Quetiapine/Prazosin (Adjuncts)
(see algorithm notes for Prazosin dosing)
Adjunctive therapy
SSRI
+
Quetiapine/Prazosin (Adjuncts)
(see algorithm notes for Prazosin dosing)
If still showing clinically significant symptoms
3rd LINE
Quetiapine
Initiate 25mg/day at night. After 1 week 25mg bd.
Dosage can be increased by 50mg/day increments at monthly appointments with clinician to a maximum of 400mg/day* based on clinical response and tolerability.
If still showing clinically significant symptoms
If still showing clinically significant symptoms
4th LINE
Consider changing to alternative less evidence-based treatment
Amitriptyline
Mirtazapine
Phenelzine


ST VINCENT'S HEALTH AUSTRALIA
A+
A-
blueknot
empowering recovery from complex trauma
Blue Knot Helpline and Redress Support Service 1300 657 380
National Counselling and Referral Service - Disability 1800 421 468
Survivors
Supporters
Resources
Get Involved
About Us
Professional Community
0
Holiday Support Information
Our Helplines are open every day right through the holiday season
Blue Knot Helpline and Redress Support Service 1300 657 380
National Counselling and Referral Service - Disability 1800 421 468
The Blue Knot Foundation office will be closed from 23rd December 2022 to January 8th 2023
Looking for Support

ST VINCENT'S HEALTH AUSTRALIA

A+ A-

blueknot
empowering recovery from complex trauma

Blue Knot Helpline and Redress Support Service 1300 657 380

National Counselling and Referral Service - Disability 1800 421 468

Survivors Supporters Resources Get Involved About Us Professional Community

Series of Fact Sheets including Plain English, Easy Read and Fact Sheets in Other Languages

ST VINCENT'S HEALTH AUSTRALIA

A+ A-

blueknot
empowering recovery from complex trauma

Blue Knot Helpline and Redress Support Service 1300 657 380

National Counselling and Referral Service - Disability 1800 421 468

Survivors Supporters Resources Get Involved About Us Professional Community

Trauma classification

Blue Knot has developed a set of fact sheets which we hope will help you understand more about the different categories of trauma.

If you have experiences of complex trauma, childhood trauma, child abuse or intergenerational trauma, or are supporting someone who has, these fact sheets will be relevant to you.

Trauma-related experiences

Blue Knot has developed an extensive series of fact sheets which provide information about the stress and trauma responses, coping strategies, the impacts of trauma, identity and belonging, and recovery from trauma.

If you are a survivor or support someone who is, we have included a lot of information and tools which we hope you will find useful to better understand the experiences related to trauma.

Survivors and supporters

Blue Knot has developed fact sheets specifically for different groups of people affected by complex trauma, including childhood trauma and abuse. We have included survivor and supporter fact sheets here.

Fact sheets for professionals, including GPs, workers and managers can be found on the professional community website. There are other series of fact sheets which explain some of the issues raised in these fact sheets in more detail.

Screenshot

o see those

Centres Against Sexual Assault (CASA)

Survivors & Friends

Emergency or crisis care

A free confidential 24 hour emergency or crisis care service is available (call 1800 806 292) for victim/survivors who have recently been sexually assaulted. This includes crisis counselling support and may include access to medical care and legal processes.

Information and advocacy

Information about sexual assault is available in verbal and written form and CASAs provide advocacy in relation to legal choices, physical health concerns and safe accommodation.

Counselling and support

CASAs offer free and confidential short to medium term individual counselling to child and adult victim/survivors of sexual assault, their non offending family members/carers and significant others. They also offer group work, telephone counselling and referrals to other relevant services.

Contacts

Sexual Assault Crisis Line (Victoria) 1800 806 292

1800 RESPECT (Australia) 1800 737 732

Centres Against Sexual Assault

ST VINCENT'S HEALTH AUSTRALIA

CASA Forum
Victorian Centres Against Sexual Assault

Search

About Us | Professionals | Survivors & Friends | Community | Blog | Links | Contact Us

Links

For more information about sexual assault try the following websites

Victorian Centres Against Sexual Assault

- Ballarat CASA
- The Sexual Assault and Family Violence Centre (Barwon)
- CASA House
- Centre Against Violence (Ovens Murray District)
- Centre Against Sexual Assault Central Victoria
- Eastern CASA
- Gatehouse Centre
- Gippsland CASA
- Goulburn Valley CASA
- Mallee Sexual Assault Unit
- Northern CASA
- Sexual Assault Crisis Line
- South Eastern CASA
- SECASA Youth
- South Western CASA
- West CASA

Resources

Key Resources – Australia

- Blue Knot -www.blueknot.org.au - National Centre of Excellence for Complex Trauma

- Trauma and Substance Use booklet – NDARC 2011 https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDARC_TRAUMA_FINAL.pdf

- Phoenix Australia – Australian Centre for Post Traumatic Mental Health. https://www.phoenixaustralia.org/resources/ptsd-guidelines

Resources

Insight - trauma informed care insight.qld.edu.au –

Guidelines and toolkits for management of trauma and vicarious trauma in AOD sector.

Recognising, screening & assessing complex trauma PHN - https://www.mhpn.org.au/WebinarRecording/55/Recognising,-Screening-and-Assessing-Complex-Trauma#.XzClsyNL3GI

SHARC - Family Drug Help www.sharc.org.au

Directline 1800 888 236 https://www.directline.org.au/

NICABM 2020 https://www.nicabm.com/trauma-three-ways-trauma-changes-the-brain/

“Putting together the pieces” Responding to trauma and substance use (2014), Re-Gen

Guidelines for trauma-informed family sensitive practice - Bouverie Centre

Resources

Adult Survivors of Child Abuse:	**www.ascasupport.org**
Anxiety Online:	**www.anxietyonline.org.au**
Australian Centre for Posttraumatic Mental Health:	**www.acpmh.unimelb.edu.au**
Australian Drinking Guidelines:	**www.alcohol.gov.au**
Australian Drug Information Network:	**www.adin.com.au**
Beyondblue:	**www.beyondblue.org.au**
Black Dog Institute:	**www.blackdoginstitute.org.au**
Dual Diagnosis: Australia and New Zealand:	**www.dualdiagnosis.org.au**
Drug information and advice:	**www.saveamate.org.au**
Drug information and research:	**www.druginfo.adf.org.au**
Drug information, services, information and shared stories:	**www.somazone.com.au**
Family Drug Support:	**www.fds.org.au**
Headspace:	**www.headspace.org.au**
HIV, sexual health and drug information for lesbian, gay, bisexual and transgender communities:	**www.acon.com.au**
Mental Health Net:	**www.mentalhelp.net**
Mental Illness Fellowship:	**www.mifa.org.au**
Quitnow:	**www.quitnow.info.au**
Reach Out!:	**www.reachout.com.au**
SANE:	**www.sane.org**

References

Clotre, M. ICD 11 Complex post traumatic stress disorder: simplifying diagnosis in trauma populations. The British Journal of Psychiatry (2020) 216, 129–131.

Comorbidity Guidelines (2020) https://comorbidityguidelines.org.au/

Gill, Richard (ed) Addictions from an Attachment Perspective Karnac (2014)

Jowett S, Karatzias T, Albert I. Multiple and interpersonal trauma are risk factors for both post-traumatic stress disorder and borderline personality disorder: A systematic review on the traumatic backgrounds and clinical characteristics of comorbid post-traumatic stress disorder/borderline personality disorder groups versus single-disorder groups [published online ahead of print, 2019 Aug 24]. Psychol Psychotherapy.

Jowett S, Karatzias T, Shevlin M, Albert I. Differentiating symptom profiles of ICD-11 PTSD, complex PTSD, and borderline personality disorder: A latent class analysis in a multiply traumatized sample. Personal Disord. 2020;11(1):36-45.

Najavits, L. M. and D. Hien (2013). "Helping vulnerable populations: A comprehensive review of the treatment outcome literature on substance use disorder and PTSD." Journal of Clinical Psychology 69(5): 433-479.

Najavits, L. M., et al. (1997). "The link between substance abuse and posttraumatic stress disorder in women." The American Journal on Addictions 6(4): 273-283.