National Comorbidity Guidelines

Face-to-Face Training Program

Module 6: Post Traumatic Stress Disorder

Participant Workbook

Funded by

Australian Government
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Delivered by

THE UNIVERSITY OF SYDNEY
Matilda Centre

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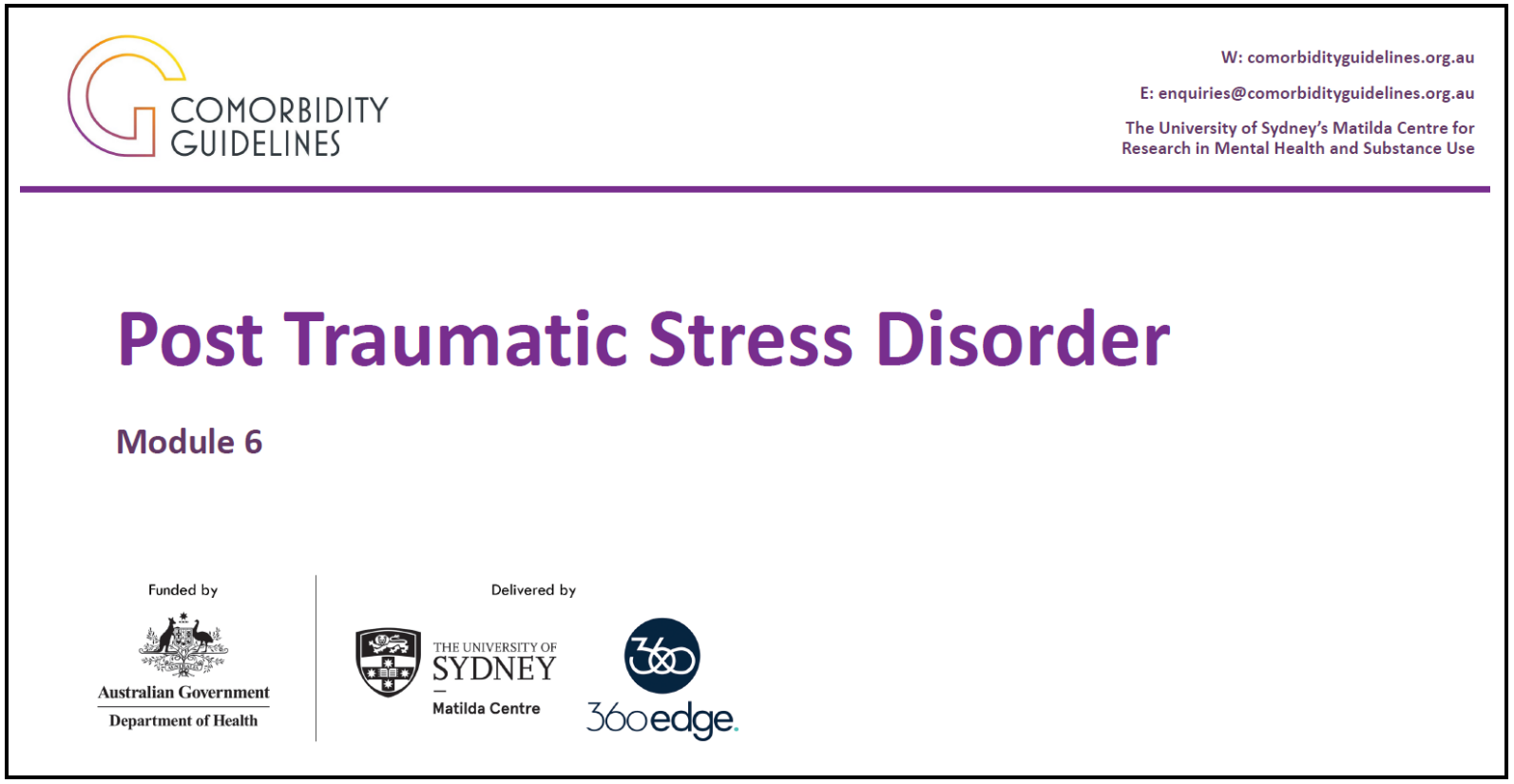

COMORBIDITY GUIDELINES

W: comorbidityguidelines.org.au

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The University of Sydney's Matilda Centre for Research in Mental Health and Substance Use

Post Traumatic Stress Disorder

Module 6

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PTSD

Agenda

Understanding trauma and post traumatic stress disorder

Helping clients with AOD use and post traumatic stress disorder to manage symptoms

What treatments work for clients with AOD use and post traumatic stress disorder

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Guiding principles

Guiding principles

First, do no harm

Work within your capacity

Engage in ongoing professional development

Recognise that the management of comorbidity is part of AOD workers' core business

Provide equity of access to care

Adopt a 'no wrong door' policy

Guiding principles

Recognise that comorbidity is common and that all clients should be routinely screened for comorbid conditions

Conduct ongoing monitoring of symptoms and assessment of client outcomes

Adopt a holistic approach

Adopt a client-centred approach

Emphasise the collaborative nature of treatment

Have realistic expectations

Guiding principles

Express confidence in the effectiveness of the treatment program

Adopt a non-judgemental attitude

Adopt a non-confrontational approach to treatment

Involve families and carers in treatment

Consult and collaborate with other health care providers

Ensure continuity of care

What is a traumatic event?

NOTES

What is a traumatic event?

Any event that involves exposure to actual or threatened death, serious injury, or sexual violence by directly experiencing the event, or

Witnessing these events happening to another person, or

Learning that a friend or family member died suddenly through assault or accident, was involved in a life threatening event, or was seriously injured, or

Experiencing repeated or extreme exposure to aversive details of the traumatic event/s (first responders, emergency services) but not repeated exposure through media unless work related

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Prevalence of traumatic events

>80% of clients of Australian AOD services have experienced one traumatic event, and most have experienced multiple events

>50% have experienced trauma during childhood

Physical or sexual assault, witness serious injury or death, threatened with a weapon or held captive are most common

Marel C et al (2016)

NOTES

Trauma-informed care

NOTES

Trauma-informed care in AOD treatment

Practitioners

- Be aware of trauma
- Understand the consequences
- Recognise the symptoms
- Integrate this into practice

Services

- Recognise high prevalence
- Provide safe space
- Consider trauma-related needs
- Respond to trauma-related needs

NOTES

Module 6 Activity 1: Trauma-informed care reflection worksheet

How does my service apply trauma-informed care?	_____ _____
How do I apply trauma-informed care in my work with clients?	_____ _____
What are the barriers for my service to applying this approach?	_____ _____
What are the barriers to applying this approach for me as an individual clinician?	_____ _____

Before you ask about traumatic events

Consider timing of raising the issue

Ask permission to ask

Give permission for client not to respond or not to provide detail

Provide rationale for enquiry

Advise that the conversation could be distressing

Provide relevant information on confidentiality and any limitations

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Asking about traumatic events

Do not 'dig' for information

Create a safe and welcoming environment

Use slow, calm movements and a gentle tone of voice

Be mindful of the client's personal space

Adopt a non-judgmental attitude

Display a comfortable attitude when they describe their trauma experience

Affirm their disclosure without sounding patronising

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Asking about traumatic events

Ask specific questions

Consider using standardised screening tools, Trauma Life Experience Questionnaire (TLEQ), Trauma History Questionnaire (THQ)

Some people may prefer to complete a questionnaire rather than verbally disclose

Screening instruments can be downloaded for free at comorbidityguidelines.org.au

NOTES

Module 6 Activity 2: Asking about traumatic events worksheet - clinician

The facilitator will divide you into pairs for this role playing activity.

Step 1: Follow the 'before you ask' guidelines with your client

- Ask permission to ask and give permission for client not to respond or not to provide detail
- Provide rationale for enquiry and advise that the conversation could be distressing

Step 2: Ask 'Have you ever experienced any traumatic events such as witnessing or experiencing: car accidents or other types of accidents, natural disasters, war, adult/childhood physical or sexual assault, or having been threatened?' or 'Have you ever experienced, witnessed or had to deal with a traumatic event that involved actual or threatened death, serious injury or sexual assault to you or someone else?'

Step 3: Following response from your client:

1. Provide positive response to the client making the disclosure (e.g. 'Thank you for sharing this with me')
2. Ask further questions to understand the impact of the trauma (e.g. How has/have that/those event(s) impacted your life?)
3. Ask about relationship of impact of trauma to substance use (e.g. Do you think there is any link between your experiences and your substance use? In what way?)

Continued over page

Step 4: Begin case formulation, incorporating what you have learned about the trauma into the formulation. You may not yet have enough information to complete this. What else would you want to ask about?

Presenting Issues:	_____
Pattern:	_____
Predisposing Factors:	_____
Precipitating Factors:	_____
Perpetuating Factors:	_____
Protective Factors:	_____

Continued over page

Module 6 Activity 2: Asking about traumatic events worksheet – client

To establish a client to roleplay please choose from the following to build your own case study

Gender				**Age**					
Male ☐	Female ☐	Nonbinary ☐	Other ☐	Under 15 ☐	15-25 ☐	25-35 ☐	35-45 ☐	45-55 ☐	Over 55 ☐

Type of trauma	Car accident	Assault	Domestic violence	Childhood abuse	War related	Other
Witnessed	☐	☐	☐	☐	☐	☐
Experienced	☐	☐	☐	☐	☐	☐

Primary substance of concern, duration and frequency of use					
Alcohol ☐	Opiates ☐	Psycho stimulants ☐	Cannabis ☐	Hallucinogens ☐	Benzodiazepines ☐

Other (list) _____

Duration in years _____ Frequency _____

Other presenting issues				
Mood ☐	Other mental health ☐	Physical health ☐	Relationships ☐	Legal ☐

_____

_____

Module 6 Activity 3: Case study - Sarah

- Sarah, 29 year-old female.
- Recently enrolled for treatment at a public opiate substitution therapy clinic.
- She presented after relocating to the local area from interstate, and the clinic staff don't yet know a lot of her background. Like many new patients, she was quite anxious when she first presented and in her initial appointments was often tearful and keen to leave the clinic as quickly as possible.
- After a few weeks of dosing, it was noted that Sarah had been avoiding providing a urine specimen for screening. Staff attempted to speak with her each day, but she frequently had excuses and would often become agitated and desperate to leave when the issue was raised.
- Over time, Sarah started complaining of nausea and even vomiting at times when approached about providing a urine specimen, and then gradually began missing doses. The more staff attempted to obtain a urine sample, the more nauseous and distressed she became, and the worse her attendance became.
- Her attendance became erratic, and when she did present, she was agitated, anxious, and very abrupt with staff. Staff became increasingly frustrated, attempting to implement plans to ensure she provided a urine specimen. Her prescriber, and the clinic NUM each had conversations with her to explain the clinic rules, but still she would only reply 'I just can't go ok? I don't want to go in that f***ing toilet.'
- Sarah's place at the clinic was in jeopardy – staff perceived that she was clearly treatment resistant, missing too many doses, and if she couldn't adhere to the clinic rules, she would not be able to continue dosing.

Q: What clues are there in the above vignette that this client might have comorbid mental health issues? What are some possible diagnoses or issues that may be involved here? How could the treating team have adapted her treatment to improve her engagement?

Module 6 Activity 4: Case study response and discussion

Responding to Sarah

Scenario 1 (clinician doesn't address the trauma):

John, one of the clinic nurses, had been observing Sarah for a few weeks. He attempted wherever possible to build rapport with her but found her very hesitant. Nonetheless he persisted, and on one particularly bad day he took Sarah outside to let her calm down before dosing. Eventually, Sarah disclosed that she had been sexually assaulted in a public bathroom as a child. Ever since, she hadn't been able to enter public bathrooms, and felt anxious and nauseous whenever she was might have to. John empathised with Sarah and explained that they could refer her elsewhere for counselling. She would, however, need to provide urine specimens are part of her treatment.

Scenario 2 (clinician does address the trauma):

When John initially took Sarah outside to help her calm down before dosing, Sarah was quite distressed and explained that she thought she was sick. Whenever she thought about going into the patient bathroom, or any public bathroom for that matter, she felt shaky and nauseous, and noticed her heart pounding. If she could get away or stop thinking about it, she always felt better. John explained some of Sarah's symptoms as anxiety and asked her how long she had been experiencing them. Sarah became quite tearful and explained that she had had this problem since her childhood, when she was sexually assaulted in a public bathroom. With this information John was able to provide information about trauma, and symptoms of PTSD to Sarah.

Do's and don'ts of managing a client with trauma-related symptoms

- ✓ Display a comfortable attitude if the client chooses to describe his/her trauma experience
- ✓ Give the client your undivided attention, empathy and unconditional positive regard
- ✓ Normalise the client's response to the trauma and validate his/her feelings
- ✓ Praise the client for his/her resilience in the face of adversity
- ✓ Praise the client for having the courage to talk about what happened

Do's and don'ts of managing a client with trauma-related symptoms

- ✓ Use relaxation and grounding techniques where necessary
- ✓ Educate the client on what to expect if they undergo detoxification (e.g., a possible increase in trauma-related symptoms)
- ✓ Maximise opportunities for client choice and control over treatment processes
- ✓ Monitor depressive and suicidal symptoms

Do's and don'ts of managing a client with trauma-related symptoms

- ✕ Rush or force the client to reveal information about the trauma
- ✕ Engage in an in-depth discussion of the client's trauma unless you are trained in trauma responses
- ✕ Judge the client in relation to the trauma or how he/she reacted to the trauma
- ✕ Abruptly end the session
- ✕ Encourage the client to suppress his/her thoughts or feelings
- ✕ Engage in aggressive or confrontational therapeutic techniques
- ✕ Be afraid to seek assistance
- ✕ Use overtly clinical language without clear explanation

Practitioner self-care

Physical self-care	• Diet, sleep, exercise • Time for relaxation and leisure
Emotional self-care	• Opportunities to talk and debrief • Self soothing and nourishing
Professional self-care	• Support and supervision • Professional development • Workload, other workplace concerns

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Module 6 Activity 5: Self-care strategies brainstorm

Brainstorm a few specific strategies for the three areas of self-care outlined below

Physical self-care	_____ _____
Emotional self-care	_____ _____
Professional self-care	_____ _____

Post traumatic stress disorder

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What is PTSD?

Key features

Exposure to a traumatic event/s

Recurrent, involuntary intrusions (memories, dreams, dissociative reactions)

Persistent avoidance of stimuli associated with the event

Negative changes in cognition and mood

Changes in arousal and reactivity

Significant distress or impairment in functioning

Symptoms lasted more than one month

NOTES

DSM-5 trauma disorders

Acute stress disorder	• Exposure to a traumatic event • Symptoms within 1 month
Post traumatic stress disorder	• Exposure to a traumatic event • Symptoms longer than 1 month
Adjustment disorder	• Emotional or behavioural symptoms in response to an identifiable stressor

There are ICD-10 codes to match these DSM-5 diagnoses found in Appendix D of the Comorbidity Guidelines

NOTES

Complex PTSD (CPTSD)

Exposure to events that are extremely threatening or horrific

Events may be prolonged or repetitive. Escape is difficult or impossible (torture, slavery, genocide, family and domestic violence (FDV), repeated childhood sexual or physical abuse)

All the criteria for PTSD plus disturbances in self organisation (DSO) with severe and persistent:

- Problems in affect regulation
- Beliefs about being diminished, worthless or defeated with deep and pervasive feelings of shame, guilt or failure related to the traumatic event
- Difficulties in sustaining relationships and feeling close to others

NOTES

PTSD and AOD use disorders

Some clients use AOD use to manage PTSD symptoms

AOD use can increase the risk of exposure to further trauma

Trauma-related symptoms can increase in frequency when someone ceases AOD use

NOTES

Helping clients with AOD use and PTSD to manage their symptoms – what works?

Considered more difficult to treat than either condition alone

Not necessary to achieve abstinence before starting PTSD treatment

Treat in an integrated way

Brief psychoeducation

Symptom management including relaxation

Monitoring environmental factors (comfort, privacy, safety of treatment space)

Physical activity

Yoga

NOTES

Module 6 Activity 6: Practicing symptom management - anxiety reduction techniques

This activity provides an opportunity to practice and experience two techniques that can be helpful to clients in managing trauma-related anxiety.

1. Pair up with another participant
2. Open the worksheets section from the appendices of the Comorbidity Guidelines: https://comorbidityguidelines.org.au/guidelines/worksheets
3. Download the two worksheets listed below:
    - Controlled abdominal breathing
    - Visualisation and Imagery
4. Each person chooses one technique and guides their partner through it using the instructions on the worksheet

PTSD treatments – past focused therapies

Focus on past trauma

Exposure based treatment "gold standard"

Do not exacerbate AOD use

Evidence for individual past focused psychological interventions alongside AOD treatment

Support for exposure based treatment combined with psychoeducation, coping skills training and relapse prevention

COPE program demonstrated reduction in PTSD severity and AOD use

NOTES

PTSD treatments – present focused therapies

Usually CBT based that focus on coping skills

May not revisit the traumatic event

Delivered individually and in group formats

Narrative review concluded no more benefit than routine AOD treatment

Some improved AOD outcomes from the *Seeking Safety* program

NOTES

PTSD treatments - EMDR

Eye movement desensitization and reprocessing (EMDR)

Assumption that information processing is disrupted by overwhelming emotions during trauma

Helps process traumatic memories by focusing on the imagery of a trauma, negative thoughts, emotions and body sensations whilst following a sequence of therapist-led guided eye movements

One small pilot for PTSD and AOD-related conditions found significant improvements in PTSD symptoms only

NOTES

PTSD treatments - pharmacotherapy

Pharmacotherapy recommended as an adjunct to trauma focused CBT if required

Little evidence of improved outcomes combining psychological interventions and pharmacotherapy

Selective serotonin re-uptake inhibitors (SSRIs) recommended as first line option

Mirtazapine and Tricyclic anti-depressants (TCAs) recommended only as a second line option

Phenelzine for people with treatment-resistant symptoms

Refer to section B6 of Comorbidity Guidelines for further information

NOTES

PTSD treatments – e-health

No e-health for comorbid PTSD and AOD use disorders

E-health for PTSD can reduce PTSD symptoms

Online Support with low level care e.g. *PTSD online, PTSD program*

Recent mobile apps e.g. *PTSD Coach*

It may be useful to consult https://psyberguide.org/apps/ prior to recommending an app to clients to obtain the latest ratings based on researcher reviews

NOTES

www.comorbidityguidelines.com.au