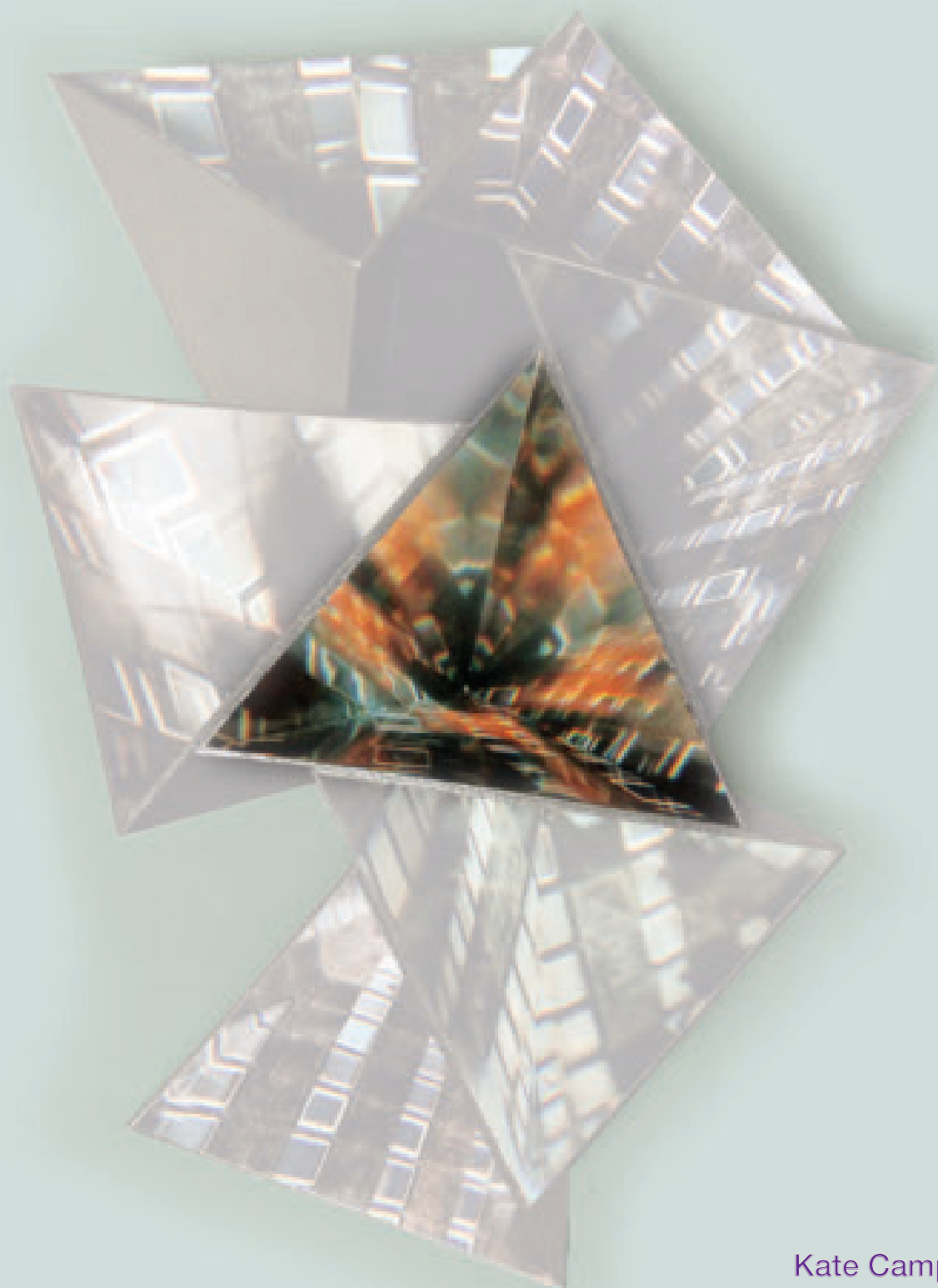


Eastern Trauma Advisory Panel Trauma, Alcohol and Drug Comorbidity:

An investigation into the issues associated with post-traumatic stress disorder in terms of individual trauma, agency responses and community involvement in Northern Ireland.



Kate Campbell



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Glossary

Addiction: A chronic, relapsing disease characterised by compulsive drug seeking and use and by long-lasting changes in the brain.

Anxiety Disorders: Varied disorders that involve excessive or inappropriate feelings of anxiety or worry; examples are panic disorder, post-traumatic stress disorder (PTSD), social phobia and others.

Comorbidity: The occurrence of two disorders or illnesses in the same person, either at the same time (co-occurring comorbid conditions) or with a time difference between the initial occurrence of one and the initial occurrence of the other (sequentially comorbid conditions).

Condition: A disease, illness or any condition which may be physiologic, mental or psychological condition or disorder. Condition and disorder are used interchangeably in the research document except when referring to post-traumatic stress disorder.

Depression: A disorder marked by sadness, inactivity, difficulty with thinking and concentration, significant increase or decrease in appetite and time spent sleeping, feelings of dejection and

hopelessness, and, sometimes suicidal thoughts or an attempt to commit suicide.

Dual diagnosis: Another term used to describe the comorbidity of a drug use disorder and another mental illness.

Mental disorder: a mental condition marked primarily by sufficient disorganisation of personality, mind and emotions to seriously impair the normal psychological or behavioural functioning of the individual. Addiction is a mental disorder.

Post-Traumatic Stress Disorder (PTSD): A disorder that develops after exposure to a highly stressful event, for example, wartime combat, physical violence or natural disaster. Symptoms include sleeping difficulties, hypervigilance, avoiding reminders of the event and re-experiencing the trauma through flashbacks or recurrent nightmares.

Self-medication: the use of a substance to lessen the negative effects of stress, anxiety or other mental disorders (or side effects of their pharmacotherapy). Self-medication may lead to addiction and other drug- or alcohol-related problems.

Eastern Trauma Advisory Panel

The Eastern Trauma Advisory Panel (ETAP) covers the catchment areas of the Belfast and South Eastern Health & Social Care Trusts. It is hosted by the Belfast Health & Social Care Trust and Co-Chaired by John McGeown, (Co-Director Mental Health, Belfast HSC Trust) and Sandra Peake (CEO, WAVE). Panel membership includes representatives from approximately 38 organisations from the voluntary/community, and statutory sectors as well as

two individual service users. The role of the Eastern Trauma Advisory Panel (ETAP) is to advise and influence the Belfast and South Eastern Health Social Care Trusts and other agencies in order to improve the development and co-ordination of quality services to address the needs of those affected by the 'troubles'. This piece of research was commissioned by ETAP to investigate issues associated with trauma and substance comorbidity.



Research aims

This small-scale research project seeks to address a number of issues concerning and relating to trauma, alcohol and drug comorbidity. The resulting report is a first stage exploration of the effects of trauma and addiction and seeks to act as part of a journey towards a planned seminar in 2011 to explore the issues at greater depth. The aim is not to produce a definitive work on the issue, however it is hoped that the information collated from the literature and from people working in the field of trauma and substance misuse will raise awareness and stimulate further debate on the issue.

The onset of post-traumatic stress disorder can typically precede the onset of substance abuse.

People diagnosed with the comorbidity of post-traumatic stress disorder and substance abuse are at a higher health risk for example, self-harm. It is important that those with post-traumatic stress disorder receive appropriate treatment and that substance abuse (misuse and addiction) is assessed, monitored and supported. Since comorbidity is high, one might assume that it is also important that people with a substance abuse be evaluated for post-traumatic stress disorder. The aim of the project is; initial review of literature on trauma, comorbidity and intervention strategies; semi-structured interviews with a small number of practitioners; analyse and discuss findings and to conclude with recommendations.



Chapter 1

Historical Context of Northern Ireland and the Legacy of Conflict

The backdrop of 40 years of civil conflict and the devastation wrought by the 'troubles' has, one would imagine, profoundly affected the mental health and well-being of a large percentage of the Northern Ireland population. The widespread and unpredictable violence that took place across Northern Ireland over a forty year period has directly resulted in over 3,600 deaths and according to official figures injuries to an estimated 40,000 (Fay, Morrissey & Smyth (1997); McKitterick, Feeney & Thornton (2001; Smyth, M., 1997). A study by Smith (1987) highlighted the considerable social strain that "troubles'-related' deaths have inflicted on the population and the personal affect of conflict on a very high percentage of the population; Smith (1987) found that 10% of the population had a relative killed as an indirect consequence of the violence perpetrated during the 'troubles' and half of the population who know someone who was killed. The implications therefore are that the conflict has greatly impacted on high numbers of people in the Northern Ireland community including the Republic of Ireland and Britain.

The overwhelming numbers of those killed were young males (91%);

- 74% were under 39 years;
- 37% were under the age of 24yrs and
- 274 children under the age of 17 years lost their lives as a result of the conflict (Smyth et al., 2004).

The number of injuries is estimated to be at least 40,000 although this figure is likely to be conservative, as it is not known how many of this 40,000 suffered a major disability as a result of the 'troubles' (Smyth, M., 1997). It is estimated that with the number of deaths that occurred during the 'troubles' a conservative estimate at the very least 6,800 people have had the experience of one of their

immediate family, that is, parent or sibling - being killed in a 'troubles'-related incident. Figures documented in the 40 years of the 'troubles' reported 34,000 shootings and 14,000 bombings (Fay et al., 1997. Daly 1999).

One of the earliest studies to investigate the affect the conflict had on individuals was called The Cost of the Troubles (Fay et al., 1999). This research took the form of an in-depth study of individuals exposed to 'troubles'-related violence where a sample of approximately 1,300 people were interviewed to determine their experience of the 'troubles', the effects of this on them, and the support both required and received. Northern Ireland was divided geographically into three categories of reported levels of community violence, those of high intensity, middle intensity and low intensity, relating to the number of deaths in the given area. This research concluded that approximately 30% of those taking part in the study and who had been directly exposed to 'troubles'-related violence had symptoms approximating to post-traumatic stress disorder. In their research, Smyth, Morrissey & Hamilton (2001) found that the 'troubles' have made an independent contribution to health problems in areas most affected by 'troubles'-related' violence.

Although it should be noted that there has been no epidemiological data collected, on the nature and extent of trauma in the Northern Ireland population (Muldoon et al., 2003; Bolton, 2008), one can assume that the figures for post-traumatic stress disorder will lie in the upper range of international estimates compared to other countries including South Africa, Israel and Lebanon, who also have experienced a recent history of violence (Levinson et al 2007).



Chapter 2

Trauma and Northern Ireland

Given the backdrop of almost 40 years of conflict, Northern Ireland provides a unique environment for the study of traumatic events and their impact on the population. Studies that relate to health in Northern Ireland have shown that people most directly affected by the 'troubles' are more likely to experience poor mental health and that the figures in Northern Ireland are approximately 25% higher than in England and Scotland (McWhirter, L. 2002). A relatively small number of studies of trauma have been carried out; the earliest significant study provided an in-depth study of individuals exposed to 'troubles'-related violence in three categories of high, middle and low intensities. Muldoon et al., (2003) explored the breadth of conflict experiences on a representative sample (3,000 people) of the population of 3000 people in Northern Ireland and the border counties of the Republic of Ireland; 50% of the respondents reported direct experience of a violent act during the 'troubles', for example experiencing a bomb, a riot or intimidation. These findings had gender dimensions where significantly more men than women witnessed these events. Whilst men are more likely to experience traumatic events, women are more likely to develop PTSD and in fact twice as likely as men (Bolton et al, 2008).

When O'Reilly and Stevenson (2003) carried out a secondary analysis of data as part of the 1997 Northern Ireland Health and Well-being Survey and examined the effects of the 'troubles', they found that 21% of the sample reported that the 'troubles' had either '... quite a bit' or '... quite a lot' of impact on their lives or the lives of their families. Thus areas deemed to have experienced a high density of violence are the same areas that one can assume experience high post-traumatic thus suggesting a high correlation between high violence and post-traumatic stress disorder. The study concluded that the 'troubles' represented a significant and additional

impact on the mental health of the Northern Ireland population.

Specific studies in geographical regions or communities exposed directly or indirectly to the extreme traumatic impact of a single incident, for example the Omagh bombing (1998), the Enniskillen bombing (1987), Bloody Sunday (1972), and on the lives of ex-prisoners and their families and the nature and extent of 'troubles'-related events experienced by individuals in north and west Belfast (Dorahy et al 2010). These studies have provided a very important insight into the extent of 'troubles'-related traumatic experiences and their psychological impact on both individuals and their communities in terms of leaving a violent impact and legacy.

However there has been no epidemiological study of the Northern Ireland population using validated instruments that assess post-traumatic stress disorder in relation to the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. The Department of Health Social Services and Public Safety (DHSS&PS) (2004) concluded that much more evidence is required in order to fully understand the consequences, particularly the long-term impact, on the general and mental well-being of the population and whether there is an additional burden as a result of exposure to the violence perpetrated on individuals and communities disproportionately during the 'troubles'. The psychological impact of the 'troubles' continues to be felt as issues for many in certain areas of society as professionals and communities, as society attempts to address the legacy of the impact of violence that so many years of conflict has had on very large numbers of the population.

While there is no doubt that trauma may be immediately demonstrated in the wake of the



traumatic experience, however there is evidence that the after effect of some traumatic events for some people may not manifest for decades. Some of the reasons for this delay can be attributed to “*kindling*” where long-forgotten *but deeply etched memories can be gradually primed by the accumulating reminders* of trauma that then break into consciousness in the form of intrusive memories and flashbacks or similarly people can have the

“... capacity to seal off traumatic experience as well as the process by which such experience becomes unsealed” (Allen, 1995:180).

This is where the self-defense mechanism induces an altered state of consciousness to deal with the pain of the traumatic event by reducing the person’s perception of it. Some people affected by the ‘troubles’ were able to acknowledge the impact it had on their lives and to talk openly for the first time, sometimes after as long as 25 years when they felt ‘safe’ to do so. The environment of fear created by the context of civil conflict has resulted in limited opportunities for those affected by the ‘troubles’ to ‘tell their story’ thus limiting the acknowledgement of the impact of their trauma and great difficulties in identifying who they could trust, if and when they were able to open up the dialogue, (Bolton et al., 2008).

It is difficult, perhaps impossible, to fully understand the personal impact of losing a family member through civil violence. Those who did not experience such loss can only imagine the cost and consequences of such a loss. The Cost of the Troubles (1998) study on young people’s experience of the ‘troubles’, found that there was a long-term affect on individuals and their families brought about by the death of a family member. For example one respondent stated,

“There’s a certain kind of loss... The fact of not knowing your father; it’s like a void that can never be filled no matter what happens... There’s

uncles that try to be decent to you, and there’s different men in your lifetime that try to be decent... but the loss of your father and not to know him, for him not to take you to football matches and for him not to take you fishing and for him not to walk down the street with you. It’s just a terrible, terrible loss.”

(The Cost of the Troubles Study: Do You See What I See? 1998:2)

Whilst the ‘troubles’ affected the Northern Ireland population deeply, some communities, particularly those within north and west Belfast, have disproportionately borne the brunt of ‘troubles’-related deaths, injuries and violence both inter and intra community violence (Fay, Morrissey, Smyth and Wong, 1999) and indeed sectarian divides still affect everyday life for many people, particularly young people, living in interface communities. The Centre for Social Justice (2010) found in their research that effective policy solutions including those that are community-based and locally relevant, must acknowledge how the ‘troubles’ affected and still affect the most disadvantaged people in Northern Ireland (Wales, 2010:4). People living in, for example north and west Belfast, not only had to cope with the ‘troubles’ in terms of the violence, sectarianism, fear and traumatic stress, which is further compounded by psychosocial stress such as high levels of social deprivation, high and long-term unemployment and inter and intra community division. Studies have also indicated that those living in areas of Northern Ireland where levels of violence are high show correspondingly greater levels of psychiatric distress than those living in low violence areas (Cairns and Wilson, 1984). Personal experiences such as knowing or being related to a victim and having many exposures to violent events can lead to increasing and damaging psychological ill-health. Those with personal exposure to political violence, or who had closer family ties to victims report higher post traumatic and dissociative symptoms as compared with those indirectly exposed to conflict-related violence (Shevin and McGuigan, 2003). Those with



more frequent exposure to political violence also tend to experience more PTSD symptoms (Fay, Morrissey, Smyth and Wong, 2001).

Research carried out by the Trauma Resource Centre (TRC) found that "... the psychological impact of the 'troubles' continues to be realised, and despite the cessation of widely politically motivated attacks, the events experienced during the 'troubles' still haunt the minds of many" (Dorahy et al, 2010). While many in Northern Ireland society are keen to move on and lay past hurts to rest it is however important for those affected by the 'troubles' to be supported and helped to deal with their hurt through a process of acknowledgement, mourning and rebuilding that can lead to ownership of the process by the community at large.

Victims or those affected by the 'troubles' are a reminder of the past. The community response to a traumatic event is a powerful influence on the ultimate resolution and the response from the community is, as Herman (2001) reminds us, part of the healing process in that recognition and restitution help to rebuild the survivors' sense of order and justice.

Although, at the time of writing this report, civil violence has largely subsided there still exists a 'fragility' in many communities, particularly in socially and economically disadvantaged areas, that relates to the legacy of the 'troubles'. Many of the people and communities profoundly affected in these areas have known severe disadvantage and heightened community conflict and there are correspondingly high rates of mental ill health, addiction, unemployment and conflict related trauma (NINIS, Multiple Deprivation Indicators, Results SOA 2010).

There is much evidence supporting the damaging psychological effects on large numbers of the population of Northern Ireland, as evidenced by high rates of mental health, injuries from shootings and bombings and 'troubles'-related referrals. It is important to consider that there is lack of psychological research that uses psychometrically sound measurements, to assess the exposure to violence related to the 'troubles'. There is a belief by health professionals and community based support organisations that post-traumatic stress disorder (PTSD) is at least anecdotal and much more common than first expected. However under-diagnosed, the consequence of the 'troubles' PTSD creates a specific and significant health need in the adult population (Daley, 1999). This is hugely significant in terms of health services budgets and in the high level of services required to deal with the need. Although estimates of the prevalence of trauma will vary depending on the measurement tools, diagnostic criteria and sample size used; those studies that are able to provide robust information and analysis of the extent of exposure in the population are invaluable for health and social care planning, levels of service provision and overall policy making.



Chapter 3

Post-traumatic stress disorder (PTSD)

The immediate and short-term impact of a traumatic event is fear and shock, resulting in numbness where there is a failure to fully process what has happened.

It is a complex, often chronic and debilitating mental disorder that develops in response to a catastrophic event. The definition for PTSD used in this research is the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association and provides a common language and standard criteria for the classification of mental disorders. The DSM-IV refers to the fourth publication in 1999 and PTSD is defined as

“the personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate ... The person’s response to the event must involve intense fear, helplessness, or horror.” (American Psychiatric Association, 1994:424).

Other emotional responses include guilt, shame, intense anger or emotional numbing (NICE 2005). PTSD can be viewed as a normal reaction and can be expected to appear in anyone who has been exposed to an event that is not normal.

Studies carried out into the health of adults in Northern Ireland have found that PTSD is a specific and significant need (Bolton et al., 2008). Studies carried out by O’Reilly and Stevenson (2003) provides robust indications that the conflict has resulted in many people experiencing both conflict related trauma along with additional non-conflict related events also (cited in Bolton, 2008). PTSD is

one of the most prevalent disorders in Northern Ireland and in the same research findings indicated that there is also a high prevalence of anxiety, panic attacks and alcohol abuse associated with those people deemed to suffer from PTSD.

Although the core PTSD syndrome involves seventeen symptoms these can generally be divided into three symptom clusters, that is:

- *intrusion (re-experiencing the trauma),*
- *hyperarousal (a permanent state of alert) and*
- *constriction (numbness and detached).*

Psychological trauma is characterised by feelings of powerlessness, intense fear and the ‘victim’ is rendered helpless by an overwhelming force. It is little wonder that traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition and memory (Herman 2001). Whilst people who have endured horrible and dangerous events often suffer predictable psychological harm, there is a spectrum of traumatic disorders that range from the effects of a single overwhelming event to the more complicated effects of prolonged and repeated abuse (Herman, 2001). PTSD is a multifaceted disorder and in severe cases it can disrupt virtually every aspect of normal functioning.

Traumatic syndromes, according to Herman (2001) have basic features in common and therefore the recovery process, one assumes, will follow a common pathway. However others say that because of the complexity of the disorder it presents multiple targets for both assessment and intervention (Weathers, Keane & Foa, 2009).

After a severe shock people are said to be in a stressed condition and this condition can be viewed as normal given the circumstance of being exposed



to an unexpected and threatening event that is not normal. The reaction is individual, and can vary from person to person although the majority of people will, after a period of time readjust and begin to move on with their lives. It is recognised that each traumatic experience is unique. The effects of trauma are a combination of the event itself, the consequences for that individual, possible previous trauma, psychiatric history and the individual's own coping mechanisms including the context in which the event takes place.

Resilience in traumatic situations exhibited by some people is an area that is noted by some as "... *the ability to maintain a stable equilibrium*". Although it is obvious that this is an area that requires further research (Bonanno, G.A, 2004).

The three symptom categories associated with people who have PTSD are that they tend to stay in a state of alertness and are normally always expecting danger; they relive the experience often through nightmares or flashbacks that typically involve extremely vivid visualisation and other sensations such as noise, smells and painful bodily sensations associated with the original trauma (Allen, 1995), rather than simply recalling the experience and lastly they exhibit the latent concept of dissociation where the person will avoid talking about the traumatic event or experience and normally have no interest in things that once mattered when dealing with people. This latter state tends to leave people feeling numb and cut off from their friends and family and incapable of benefiting from support or guidance at early stages in the process of dissociation.

Intrusive symptoms are recurrent and distressing recollections of the event and will include flashbacks, thoughts and nightmares or disturbing dreams of the event. People tend to involuntarily re-experience aspects of the trauma in a very vivid and distressing way, so that they feel as if the event is recurring. Intrusive and repetitive images or other sensory impressions such as smells or sounds are reminders of the traumatic event and arouse intense distress.

Hyperarousal symptoms are expressed in sleeping difficulties such as falling or staying asleep, irritability and outbursts of anger, and include hypervigilance that continually scans the environment for threat. Goals and purposes for the short-term and long-term are put on hold and staying on track can often get lost as concentration levels are reduced.

Constriction symptoms include avoidance of the trauma by avoiding activities or places associated by the event, a detachment from others or emotional numbing, and loss of trust (Dass-Brailsford & Myrick, 2010). People feel a detachment or estrangement from other people and a loss of confidence often with those they have significant relationships with in the course of their lives. There is a strong desire to avoid talking about 'the' trauma often resulting in people tending to keep details of the event, their reactions, and intrusive thoughts, etc., secret. Sometimes these actions are an inbuilt defence mechanism to protect family, friends or colleagues as well as an inability to recall some important aspect of the trauma. There is a sense of a foreshortened future, for example, the person often does not expect to have a career, marriage, children or a normal life span.

The combination of hyperarousal and numbing gives an 'all or nothing' quality to people's emotions and a person experiencing from these symptoms may present themselves as emotionally remote and unresponsive one moment while a seemingly minor incident launches them into a panic or rage. Herman (2001) refers to this vacillation as a 'dialectic of trauma' and gives the example of being caught between the extremes of amnesia of the event at the same time reliving the trauma. Thus the symptom clusters are in conflict with each other and this instability further exacerbates the traumatised person's sense of unpredictability and helplessness.

As trauma affects the person physiologically, psychologically and socially; it has been described as a state of turbulence and complexity where symptoms present a vicious circle of intrusive experiences.



Physically the traumatised body is not a normal body because it lives in a constant state of terror. When faced with an overwhelming threat or danger humans use flight, fight or freeze as responses to survival. In flight or fight the body will, through raised levels of anger have energy to attack the source of danger and it will also have the energy to retreat from the source of danger as a flight situation. When the body is traumatised instead of attacking or retreating it tries to do both at the same time thus swinging between two extremes. This is why those who exhibit these behaviours can be so erratic and change quickly. Levine (1997) identifies an immobility or 'freezing' response where the body uses the ability to go into and out of this natural response thus avoiding the debilitating effects of trauma; Herman too identifies this state as one of "detached calm, in which terror, rage and pain dissolve" and that the person's perceptions may become numbed or distorted, for example, their time may be altered as people describe events going into 'slow motion'.

Research into the experiences of people exposed to conflict or other related traumatic experiences found that there was a prevalence of physiological health problems and were more likely to have chronic conditions such as pain, for example in their back or stomach anxiety attacks, cardio vascular disease, diabetes and chronic fatigue (Boscarino 2004; NICTT 2009). People with PTSD had twice as many days where they were not able to carry out normal activities as those who did not have PTSD.

People who have experienced trauma are aware of the fragility of human connections. The sense of safety in the world or basic trust is, according to Herman (2001), acquired in the earliest life and as this forms the basis of all relationships, when it is broken or damaged the sense of isolation and loss contribute to depression. Depression can be compounded by the use of drugs taken to alleviate anxiety - such as alcohol - so it is unsurprising that depression is often a significant complication of PTSD.

The excessive use or abuse of alcohol and drugs produce similar numbing effects, as traumatised people are unable to spontaneously change the numbing or detachment effect. Dass-Brailsford & Myrick, 2010:203 stated that

"... it is not unusual for individuals experiencing trauma to become involved in self destructive behaviours such as substance misuse or self harm as a way to cope and manage unbearable distress."

Complex post-traumatic stress disorder (PTSD)

People experiencing complex post-traumatic stress disorder have prolonged and repeated trauma symptoms. They have additional symptoms to those mentioned earlier for PTSD and on a much more severe scale and over a longer period. This condition is described as chronic and may include, for example, survivors of sexual abuse or survivors of extreme situations where the persistent anxiety, personality disorder or depression is prolonged, has been defined by Herman (2001) as 'complex post-traumatic stress disorder'. This group of symptoms referred to as 'complex PTSD' generally results from chronic conditions and includes markedly impaired interpersonal relationships, sense of self, significant alterations of self and towards others, loss of beliefs accompanied by feelings of hopelessness and despair. This disconnection from family and friends and the inability to relate to others has consequences for utilising social supports that are often used to buffer individuals against emotional pain. In their research examining the experiences and consequences of the 'troubles' in north and west Belfast from the perspective of those attending the Trauma Resource Centre for treatment, found that the majority had complex PTSD associated with traumas experienced as both child and adult exposure to, in this instance the 'troubles' (Dorahy et al 2010). The effects of complex post-traumatic stress disorder are such that they impact on the inner core of the self-structure and destroy the PTSD



sufferers' fundamental assumptions about safety in the world (Wilson et al 2001; Herman 2001).

In conclusion it is clear that trauma causes a fragmentation and overwhelming in terms of managing interpersonal relationships, trusting others and sense of despair and as Herman (2001:34) identifies "*tears apart a complex system of self protection that normally functions in an integrated fashion*" and this analysis has profound effects on the individual, their social framework, treatment and recovery.

Post-traumatic stress disorder sequelae

It is now recognised that the person's perception of the traumatic event can be the major cause of the symptoms of the post-traumatic stress disorder. Historically this has been the subject of debate though it was the longstanding and severe psychological problems of many war veterans, particularly the Vietnam veterans and more recently rape survivors that changed the view of clinicians and researchers and convinced them that exposure to horrific stressors could induce significant psychological symptoms even in people with sound personalities (NICE 2005). Post-traumatic stress disorder (PTSD) was classified in 1980 when a body of research and literature emerged and the American Psychiatric Association included in its official Manual of Mental Disorders the new category of PTSD.

A substantial number of people with PTSD show high levels of natural recovery within the initial months and years after the traumatic event. The majority of people recover from traumatic experiences though it takes time, often taking 4-6 years; however between a quarter and a third either feels they still have not or do not fully recover, for example, in rape and hostage incidences. Long term follow up investigations found that almost half (46%) of people still reported *constricted* symptoms and almost one third still had *intrusive* symptoms (Herman, 2001). Approximately 30% of those initially developing PTSD will continue to have symptoms for three years

or longer and the risk of developing secondary problems such as substance abuse increase.

It is evident from the research that even long after the traumatic event many traumatised people feel that they have been changed forever; indeed some feel that the loss is so significant that they report that part of them has died (Bolton 2009).

Symptoms of post-traumatic stress not only cause the sufferer considerable distress; there are adverse effects on their social relationships often leading to social withdrawal. There are often significant effects on their educational and occupational functioning and it is not uncommon for PTSD sufferers to lose their jobs due to their re-experiencing symptoms or lack of sleep and concentration problems. The resulting financial problems may become an additional source of stress or indeed extreme hardship such as homelessness. Family, marital or parenting difficulties and the break-up of significant relationships can lead to the problems being compounded.

If the post-traumatic symptoms are not addressed then sufferers are in danger of descending into a spiral of disconnection with people, social isolation, loneliness, poor physical health, depression or other anxiety disorders and maladaptive coping mechanisms such as substance abuse. The use of alcohol, drugs, caffeine or nicotine in order to cope with their symptoms may, eventually, lead to dependence on these substances.

This study is concerned with comorbidity; the relationship between PTSD and another condition, for example, alcohol and or drug abuse, that will form part of the literature review. There are now two conditions 'playing off' each other and the key issues for this are:

- substance use as a coping mechanism,
- dependence and misuse of alcohol and prescribed drugs and
- physiological damage.



Coping mechanisms

The most common coping strategy is to use substances such as alcohol and prescribed drugs/medication to ease or numb the pain of the trauma and the associated symptoms. Alcohol abuse is the most prevalent comorbid condition with post-traumatic stress disorder (Kessler 1995). At lower doses alcohol can act as a stimulant and may also lower anxiety and inhibit fear; therefore it is evident how this may, in the short-term, assist the person suffering from post-traumatic stress disorder to cope with a number of physical symptoms such as hyperarousal and provides ease for some social situations. However this relief is only temporary and the use of substances to reduce these symptoms is ultimately harmful to the individual, their relationships and wider circle, to be productive in work and life in general. At higher doses alcohol acts as a depressant and alcohol misuse or dependence may also be responsible for causing interpersonal problems or indeed exacerbating them. In particular trauma survivors may self-medicate using stimulant or other drugs to maintain alertness and psychoactive drugs to try to block the distress of intrusive thoughts and traumatic memories (Daas-Brailford and Myrick 2010).

Although substance abuse could bring some short-term relief it may heighten others and is a barrier to processing the trauma. There appears to be a suggestion that self-medication using prescription drugs, was prevalent during the 'troubles' when many people self-medicated in order to function. A majority of adults (84%) take sedatives, tranquillisers or anti-depressants daily or almost daily (DHSSPSNI 2002/03).

"During the 'troubles' many women developed addictions to prescribed medication like Valium to deal with the depression they suffered as a result of the men they lived with being killed. Men dealt with the 'troubles' more with alcohol". (Witness at the Centre for Social Justice Policy hearing (2010).

The high prevalence of prescription drug misuse is specific to Northern Ireland, in contrast with the UK, and recent evidence suggests that this could be largely associated with the management of illnesses associated with the 'troubles'. The study by the mental health charity Threshold (2010) found that in Northern Ireland there were 75% more prescriptions for tranquillisers than in the rest of the UK and that doctors in Northern Ireland also have the second highest prescribing rate of anti-depressants in Europe. A statement from the Central Health and Social Care Board, admitted that the figures were high and stated,

"Northern Ireland does have a higher usage of these drugs (tranquillisers and sleeping pills) which has been attributed partly to the legacy of the 'troubles'." (Rainey, S, Belfast Telegraph, 24/1/2011)

Substance misuse problems may be defined as the consumption of alcohol or illegal drugs such as marijuana or cocaine or the misuse of prescription drugs, that is, using them in a way that was not prescribed (ISTSS, 2001). Substance use disorder encompasses two different types of problems, that of dependence and misuse. Alcohol *dependence* occurs when high consumption causes a significant degree of harm in terms of physical, social and psychological well-being. Individuals will continue to use the drug (alcohol) when going about their everyday tasks at home or work even when it is hazardous to do so and even though it may be causing major problems. Where they have lost the ability to either control or curtail its use; where a great deal of time is spent trying to obtain the substance or recovering from the effects of its use and when more of the substance has to be taken to get the same effect (Daas-Brailsford and Myrick, 2010). Substance *misuse* affects not only the individual; it can affect the whole family and including the community. The adverse effects on family members are considerable with marriages twice as likely to end in divorce, higher rates of domestic



violence and an increased likelihood of children having an alcohol problem is a feature of alcohol misuse (Murphy et al, 2005 cited in NICE).

There is clear evidence that stress and adverse life events can trigger excessive drinking of alcohol and may further predispose individuals to the development of alcohol dependency (NICE, 2010). Addiction and poor mental health are also inter-related with drug and alcohol misuse. Legally prescribed drugs are widely available and can be highly addictive particularly with high frequency use (Wales 2010).

There are individual health risks for people with alcohol dependence as they are often unable to take care of their health needs during drinking periods and consequently they are at risk of developing a wide range of health problems. Mortality rates are high for those with substance abuse; almost four times the rate for those without alcohol dependence. High dependency levels for substance abuse increase their health risks for example, involvement with peer groups that risk exposure to violence, crime, abuse and accidents. Those with PTSD experience physical problems with pain (back and

severe headaches), sleeplessness or drowsiness, feeling nauseous, low energy levels, agitation such as shaking and high blood pressure that increases the risk of heart disease. Memory and information processing are often impaired and can result in poor judgment and decision-making capacities.

Summary

Mental health problems and substance abuse are deeply entrenched social problems in Northern Ireland and, disproportionately so for those communities and individuals that are directly involved in or have experienced violence during the 'troubles'; more so for those directly involved, but nevertheless those indirectly involved cannot be neglected in terms of their psychological needs. Whilst a number of factors such as poverty, benefit dependency, social exclusion, unemployment, poor health, low education achievements, intergenerational poverty, family breakdown and dysfunction all contribute to the difficulties that many people in poorer socio-economic areas experience, one may assume that the legacy of the 'troubles' will further fuel the cycles of addiction and poor mental health.



Chapter 4

Comorbidity

The term 'comorbidity' is best understood by the definition of having two, or more, conditions at the same time that exist simultaneously but independently of each other. This research is looking at the implications of a person having both post-traumatic stress disorder (PTSD) and substance abuse (alcohol or prescription drugs) at the same time and how this might affect the person in terms of well-being and treatment.

In recent studies of people with PTSD it has been found that they usually have at least one other psychiatric condition or disorder; in fact comorbidity with PTSD is the norm (Foa, Keane, Friedman and Cohen, 2009). Yet recent treatment outcome studies routinely exclude people with "... *significant comorbid conditions and fail to assess for them*" in their assessment procedures (Najavits, Ryngala, Back, Bolton, Mueser & Brady, 2009:508). In the USA, findings indicate that 80% of people with PTSD have lifetime depression, another anxiety disorder or chemical abuse or dependency (Foa et al). In the UK and Northern Ireland there is evidence that PTSD and comorbidity conditions occur in individuals who have experienced traumatic events are more likely, up to 9.3 times, to have symptoms of one or more mood, anxiety or substance use conditions than those in the general population (Davison et al 1991; Bolton et al, 2008). In the study carried out by the Northern Ireland Centre for Trauma and Transformation (NICTT) found that the comorbidity of PTSD and Major Depressive Disorder (MDD) indicated that two-fifths (39%) of individuals who had PTSD at some point in their lives would also have had MDD at some point in their life and, conversely one fifth (20%) of people with MDD at some point in their life will also have had PTSD. It is unsurprising that depression follows in a syndrome that entails pervasive avoidance, isolation and has no sense of

happiness or life enjoyment as PTSD does (Allen, 1995).

A significant number of studies (Breslau et al, 1998; Kessler et al, 1995) have found evidence supporting the relationship between PTSD and substance misuse. In fact the dual diagnosis of PTSD and substance misuse is common and this co-occurrence has been found regardless of the nature of the trauma or the substance used or misused. Whilst there is some debate surrounding the sequence of onset psychological disorders and the relationship to traumatic disorders, both Kessler et al (1995) and Perkonig et al, (2002) report that "... PTSD was more likely to occur prior to affective and substance abuse disorders; but less likely to occur prior to comorbid anxiety disorders." (Bolton, 2008:13). While PTSD and substance misuse commonly occur, several reasons for this occurrence have been identified for example, the theory that drug and alcohol problems happen before PTSD develops and that the use of alcohol and drugs puts people at greater risk for experiencing traumatic events. Furthermore that people with PTSD use substances as a way of reducing distress appears to be tied to particular PTSD symptoms, for example, as a means of 'self-medication'. This 'self-medication' is often in response to dissociation where the person feels overwhelmed and numb and unable to deal with the traumatic events and uses substances as an avoidance symptom thus distancing themselves from the state of unbearable intense arousal associated with the trauma (Allen, 1995). The comorbidity of PTSD and substance abuse is often described as a 'downward spiral' where PTSD symptoms are common triggers of substance use, which in turn can heighten PTSD symptoms. Female substance abusers show high rates (30% and 59%) of having a dual diagnosis (Najavits 1997).



There is a growing body of literature that suggests a strong association between PTSD and Substance Use Disorders (SUD) thus highlighting issues for both clinical practice and public health agendas. High rates of trauma exposure have been found in substance using populations with a high incidence of individuals seeking treatment for substance misuse who were diagnosed as having PTSD (Karadag 2005; Foa, Keane, Friedman and Cohen 2009). Given these assertions it is important to examine what effect comorbidity is having on people in terms of:

- a) how they present themselves to the medical profession and
- b) why assessment and treatment present complexities and difficulties

It is useful to define both PTSD along with substance misuse and dependency as this will assist the readers understanding of each condition and enable those concerned to respond appropriately to the coalescence of these conditions.

Comorbidity of post-traumatic stress disorder and substance abuse present challenging and difficult assessment and treatment issues for the medical profession.

'... services for people with dual diagnosis - mental illness and substance misuse - are the most challenging clinical problem that we face'.
(Appleby, L. 2004 - National Service Framework for Mental Health)

The complexity of issues makes diagnosis, care and treatment more difficult as the person is at a higher risk of relapse, readmission to hospital and suicide. It is difficult for people suffering from PTSD to confront the feared and avoided memories and reminders of the traumatic experience. In understanding PTSD we know that people tend to withdraw from social contact, have overwhelming feelings of shame, guilt and anger and have little energy or motivation to

address their own needs. Many PTSD sufferers may not recognise that their distress has a name (post-traumatic stress disorder) and they may feel that the distress will pass 'in time'. For others they may be reluctant to admit that they are experiencing any form of distress, which may be due to fears and associated stigma of mental illness; or they may recognise their distress and feel that they should be able to 'get over it' through using their own resources. PTSD symptoms of impulsivity and social isolation can lead to substance misuse, as some people will use substances in order to reconnect with others.

Group symptoms such as 'complex' PTSD present complex and more severe symptom profiles especially around self-identity and relating to others and demonstrate more vulnerability to self-harm (Herman 2001). Self-harm and suicide are relatively common in people with alcohol dependence (NICE 2005).

Coping strategies such as substance abuse may initially 'mask' the distress, as will prescription medication for symptoms such as depression and anxiety. The presence of additional conditions indicates a more complex clinical presentation as this will have several targets for both assessment and treatment.

A comprehensive assessment of PTSD must therefore include an evaluation for comorbidity thereby determining what other disorders may be present, prioritising these and developing an appropriate treatment plan. It is important that the assessment is carried out by appropriately experienced staff (Foa et al., 2009; Herman, 2001; Wilson et al., 2001; NICE 2010).

People with alcohol use disorders commonly present to health, social and criminal justice agencies with the problems associated with their alcohol misuse rather than seeking help for the cause of the alcohol problem itself; it may not be until the problems are



more chronic than a comprehensive assessment is carried out (NICE, 2005). The person may 'present' him or herself, for example, and enter treatment to address a substance abuse issue or look for treatment to address a mental illness, such as depression and general anxiety, somatic complaints, inability to work or sleep problems. They may not relate their symptoms to the traumatic event especially if a significant time has elapsed since the event. However the person may 'present', there are benefits in all the providers, statutory and voluntary designing and following best practice guidelines. People may seek help when maladaptive coping mechanisms have broken down, for example, a recent acute trauma incident can be fairly straightforward though for people suffering prolonged, repeated trauma, the diagnosis is usually much more complex.

It would appear that early intervention and support may reduce the burden on both the individual and society. Importantly there is evidence that suggests that the person suffering from PTSD will benefit from treatment regardless of the time elapsed since the traumatic event (Gillespie et al., 2002).

A number of well-validated, structured clinical interviews that help the diagnosis of PTSD have been developed over the past twenty years to measure trauma exposure and post-traumatic stress disorders (NICE, 2005). These include, for example,

- Impact of Events Scale - Revised (IES-R; Weiss and Marmar, 1997),
- Post-traumatic Diagnostic Scale (PDS; Foa et al., 1997)
- Mississippi Scale for Combat-Related PTSD
- PTSD Checklist (PCL; Weathers & Ford, 1996)
- Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995).

All these instruments are based on the DSM-1V definition of PTSD and standardised measures are strongly encouraged as part of best practice for clinical work and for research.

The assessment should not, in the case of alcohol misuse/dependence, be narrowly focussed, that is, only on the alcohol consumption. It is essential, that people are appropriately diagnosed and assessed in order to decide on the most appropriate treatment and management, and that risk levels are correctly assessed, for example, self harm, risk to others and the identification of co-occurring problems such as psychiatric comorbidity, physical illnesses, social problems such as housing, financial, safety, vulnerability and pregnancy are all considered as contributing factors (NTA, 2006).

Comorbid substance abuse disorders are associated with a higher level of problems and, as this often involves a chronic condition it will usually require a higher level of both medical and psychiatric intervention. It follows therefore that staff in specialist and social care services are able to appropriately diagnose and assess alcohol dependence (NICE, 2010). Similarly the complexity of PTSD symptoms and particularly the overlap with depression and other anxiety disorders make it crucial that the assessment instruments measure the symptoms uniquely attributable to PTSD rather than simply reflecting non-specific distress (Foa et al., 2009).

Individuals diagnosed with PTSD (DSM-1V) must experience trauma symptoms for at least a month after the traumatic event and the symptoms must cause clinically significant distress or impairment in social, occupational or other areas of functioning in order to fit the criteria. In a minority of people, less than 15%, there may be a delay of months or years before symptoms start to appear (McNally, 2003).

The International Statistical Classification of Diseases and Related Health Problems 10th revision (ICD-10) diagnosis requires that firstly the person has been exposed to a traumatic event and, secondly that they are suffering from distressing re-experiencing symptoms; it does not require a minimum duration. The DSM-1V diagnosis of PTSD is much stricter in that it puts more emphasis on the avoidance and numbing symptoms and that there is



significant distress or interference with social or occupational functioning and that the symptoms occur for at least one month (NICE, 2005). The diagnostic instruments therefore adhere to the DSM-IV-TR guidelines and diagnostic criteria. This includes exposure to a traumatic stressor; the development of syndrome involving re-experiencing trauma, avoidance and numbing and hyperarousal symptoms; distress and impaired functioning. A comprehensive assessment evaluates all the diagnostic criteria, associated features and comorbid disorders using a structured interview in the main (Weathers, Keane and Foa, 2009).

There has been a tendency to find appropriate referral difficult, and those with a dual diagnosis could 'fall between two stools' of psychiatric services and drug and alcohol agencies. The majority of people with comorbid symptoms of PTSD and substance abuse do not receive PTSD focussed treatment and many people receiving even several substance abuse treatments were not asked about trauma. Similarly, some mental health clinicians do

not assess for substance abuse (Najavits, 2008). The reasons for varying assessments may be understood because several questions are raised for clinicians, such as whether the PTSD is primary or secondary to comorbid disorders such as depression or substance abuse; which condition should be treated first, and whether the treatment of PTSD will lead to an improvement of the comorbid condition. A thorough assessment is always advised.

The assessment for all people presenting with PTSD should include a risk assessment for suicide, the current depression and substance misuse. This is advisable in that self-destructive and impulsive behaviours should be part of any assessment although these are not part of the core PTSD symptom complex; they are recognised as associated features of the condition and will obviously affect the clinical management of the person (Foa et al., 2009).



Chapter 5

Treatments

Clinical intervention centres when asked how to be most helpful in order to improve the distressing symptoms in post-traumatic psychological condition stated that, whilst most practitioners will agree about some general treatment principles, such as reducing physiological hyperarousal, depressive states and debilitating memories, the techniques and methods used will vary. In many cases comorbid problems are secondary to the PTSD, for example depression, general anxiety or substance abuse (NICE, 2005). The best treatment is recognised as one that is expected to ameliorate both PTSD and comorbid symptoms (Foa et al 2009). All the treatment approaches for PTSD appear to recognise that it is complex rather than a one-dimensional disorder (Wilson et al, 2001).

Broadly there are 4 main treatment approaches to comorbidity:

- 1) *Integrated* – this is where clinicians treat the conditions at the same time, by the same provider and focussing on the linkages between the conditions.
- 2) *Sequential* – the approach is to treat one condition then treat the other. Often the substance misuse is deemed to be necessary to treat prior to the treatment for PTSD.
- 3) *Parallel* – this term is also known as Concurrent where each condition is treated but in separate treatments, often by separate providers and sometimes in separate systems such as Mental Health teams dealing with PTSD and Addiction teams dealing with the substance misuse.
- 4) *Single Diagnosis* – only one condition is treated.

Whilst early attempts to treat people with comorbid disorders advocated a *sequential* approach in which the substance abuse needed to be treated successfully first and only then could the treatment for PTSD start, it is still quite common for this

approach to predominate. However research on *integrated* treatment approaches consistently indicates that it is helpful for this comorbid population (Najavits et al., 2009). A number of promising treatments with positive outcomes have been developed in the past five years. However this is still a relatively new area for treatment and research for a number of treatments has been reviewed in practice guidelines from the International Society for Traumatic Stress Studies edited by Foa et al. (2009). They further recognise that currently there are insufficient clinical trials addressing the comorbid conditions that occur with PTSD. However, that said, treatments such as in the (American) Seeking Safety model that is an integrated, present-focussed coping skills model with high flexibility and designed for PTSD and substance use disorder (SUD) is the most researched model for any diagnosis co-occurring with PTSD (Najavits 2002).

There appears to be a recent transformation in mental health services from a 'medicalised' or 'diseased' model to that of a rehabilitation model of recovery. Some are using a psychosocial model, where the person takes more responsibility for managing their trauma symptoms and accessing a range of services and rehabilitation processes designed to assist the person to live, work, learn and participate fully in their communities (Glynn, Drebing and Penk ed Foa et al. 2009). This approach is not without its challenges though it may well be more empowering for the individual as it is more person centred and designed to improve the capacity of people to regain control over their environment. This appears well suited to increase self-efficacy, such as having a strong belief in their skills and abilities, by reducing the PTSD symptoms (Bandura, 2006).

Herman (2001) suggests that given there are basic features in common, the recovery process also follows a common pathway. Treatment occurs in



stages and she argues that treatment must be appropriate at each stage and, at each stage take account of the biological, psychological and social components of the disorder. As she suggests there is no magic or quick cure for traumatic syndromes. She proposes that the most effective approach needs to be empowering for the person suffering from PTSD. The definition of empowerment given by Herman is “the convergence of mutual support with individual autonomy” and she suggests the most effective outcome is when the therapist places all their knowledge, skills and resources at the person’s disposal. She talks about this in terms of a “healing relationship” where it is essential that the survivor becomes “the author of their own recovery”. Given the traumatised person has been put in a powerless situation, a position of helplessness, it is, she suggests, central to the recovery process that they must work on the principle of restoring control to the person. The role of the therapist is crucial in assisting the person and in presenting choices as s/he works as the person’s ally. By taking this approach the person begins to make decisions and gradually takes control in their life.

The most urgent medical need when a person has comorbid conditions of both active substance abuse and PTSD is to establish safety (Najavits et al., 2009) and Herman goes so far as to say that “no other therapeutic work should be attempted until a reasonable degree of safety has been achieved”.

Protection of the individual

There appears to be a pattern of treatment approaches emerging from the literature, which has three interesting characteristics: those of ensuring that the person is physically and emotionally safe and that a pattern of healthy well-being has been initiated. Following this, that there is a reconnection and rebuilding with other people and with themselves and that the last stage is one of remembering and reconnecting for the traumatised person with their former life and acknowledging their loss (Herman, 2001). Similarly the psychiatrist James Chu proposed

the acronym “SAFER” for the ingredients relating to the early stages of therapy for remembering and exploring the trauma as follows,

“Self-care entails refraining from self-destructive and suicidal behaviour by finding better ways of soothing yourself and less destructive ways of coping with stress. Acknowledgement of trauma means accepting the role of traumatic experience in your problems rather than seeing yourself as “crazy” or “bad”, Functioning refers to the need to maintain normal functioning to the extent possible Expression refers to the need to find some constructive outlet for expressing feelings, such as art, music, physical activity, or writing. Relationships addresses the need for social supports, including a therapeutic relationship.”
(Allen, 1995:236)

It is challenging to ‘establish safety’, that is safety for self in relation to the threat or terror that traumatised the person is experiencing. This may be a place of safety where they are removed from the threat or personal safety where any risk-taking behaviour is minimised, for example, protection from self-harm in relation to alcohol, drugs or suicide risk (Herman, 2001; Foa et al., 2009). The initial premise is that survivors feel unsafe in their bodies given their emotions and their thinking is out of control therefore the focus of the intervention is to establish a pattern of eating, sleeping and exercise so that the body gets into a health promoting rhythm. In establishing safety the management of both the post-traumatic stress symptoms and the control of destructive behaviours is achieved however “the process of establishing safety as a foundation for treatment is not easy” (Allen, 1995:236).

Traumatic life events invariably cause damage to relationships and people with PTSD have survived but trust levels in people are often extremely stretched, therefore it is important to restore some minimal level of trust. If supportive family and friends are around, their care and protection can have a



strong healing influence and the recovery time is related to the quality of the individual's intimate relationships (Herman, 2001).

As stated earlier relationships will have inevitably been damaged due to the difficulties associated with building trust or the erratic behaviour displayed through guilt, shame and the emotional turmoil resulting in feeling distant and alone from people compounded with fear and helplessness. Rebuilding a sense of control and a positive view of self requires others to show some tolerance for survivors and some respect for their attempts to re-establish their autonomy and self-control. Recovery can take place only within the context of relationships; it cannot take place in isolation (Herman, 2001). As the individual becomes more accepting of themselves they are often much more able to confront their problems, conflicts and indeed acknowledge their own limitations. Developing positive emotion is necessary as these feelings go with activities that lead to growth and development. Anxiety, fear and anger can remain for quite some time but gradually with guidance and support positive feelings accompany the healthy forms of relatedness. Positive emotions may include pleasure, interest, excitement, enjoyment, pride and contentment (Allen, 1995).

Trauma inevitably brings loss that may be physical or it may include the loss of the person's internal psychological structure - that of a self securely attached to others (Herman, 2001). It would appear to be common that many survivors of trauma have feelings of a foreshortened future and part of the remembrance is to reconnect with the person's earlier life thereby restoring a sense of continuity with the past. Through encouraging them to talk about the important relationships, ideals, dreams and conflicts prior to the traumatic event it may assist with 're-creating the flow' of the person's life. The remembering and telling of the traumatic event follows and then the person is considered ready to start the grieving process. Many therapists believe that failure to complete the normal process of grief perpetuates the traumatic reaction and only in

successfully facing their loss can the person "*discover their indestructible inner life*" (Herman 2001:188)

As stated previously, the treatment of PTSD is still in early stages and virtually all the literature on the treatment for this and a comorbid condition has arisen in the past few years. There are a number of issues that should be considered as part of the management of people undergoing treatment for the comorbid conditions of PTSD and substance abuse. Best practice principles include therapist skills and training, preparing the person for treatment and ensuring their readiness to participate in such treatment. Therapists must be professionally trained and this training should include a degree, clinical internship (or equivalent) with past supervision in the specific technique or the treatment approach to be employed. People with post-traumatic stress disorder require dependable and steady therapeutic relationships; therapists should consider being involved for a reasonable time as this provides assurance for the person of the continued availability of a consistent and trusting relationship. The building of trust is a crucial issue for those experiencing post-traumatic stress disorder, for their trust in people has been severely compromised and therapies should be characterised by supportive and trust building measures (Bolton et al., 2008).

According to Herman (2001) the person may accept or may reject the diagnosis but in either instance they should be prepared for the treatment by looking at or devising a psychosocial education approach that informs them about the condition and reassures them that there are high rates of post-traumatic stress disorders among survivors of trauma. Whether there is a medical diagnosis of PTSD or a therapist is tying up the person's symptoms with a traumatic event, knowledge is power and if people are informed beforehand then they are less likely to be apprehensive and much more prepared. It comes as a relief to many people that their symptoms can be named and related to an event.



In sharing the diagnosis or assessment, the person will have discovered that there is a language for their experience and this can have a huge enabling effect for being able to share their experience with others. There is also a role for psycho-education in relation to family and friends, for if they are distressed and bewildered by a family member or friend coping with trauma, they will have difficulty being supportive, but if informed, they are prepared and far more able to tolerate the inevitable disruptions in the relationship. As stated earlier, treatment in the case of comorbidity is not a linear process and many people have on-going crises in their lives; starts and pauses in their treatment may be characteristics and indeed this may be the only way people can engage in the process of change. Talking about the trauma is hard work and it can be exhausting; coping with trauma is also hard work (Allen, 1995). Co-working with other health professionals, family members and significant others is an important part of a collaborative approach and restoring normal functions. Monitoring the PTSD symptoms along with any related problems is part of the process to improve the quality of the person's life.

As raised earlier a number of factors may deter traumatised individuals with PTSD from seeking treatment, for example, they might believe that the symptoms will ease with time; or they may assume that nothing can help them; shame may surround their trauma and they may want to avoid any reminders of their traumatic event or they may view their PTSD and/or substance misuse symptoms as a personal failure. These reactions would all be considered reasonable reactions but for many the normalisation of their symptoms results in immediate relief and reduces their reluctance to continue treatment (Foa et al., 2009).

Summary of integrated treatment approach

The majority of the literature consulted in this review tended to be taken from the USA experiences. There is a consistent message that an integrated approach best suits the treatment of comorbid conditions.

Treating both conditions at the same time is felt to be the most effective method by many clinicians and is supported by research as more likely to succeed: is more cost effective, has a higher likelihood of not relapsing and is more sensitive to the person's need and indeed favoured by people (Brown et al., 1994; Brown et al., 1999; Dass-Brailsford and Myrick 2010). Many integrated approaches to the treatment of comorbid conditions focus on empowering the individual by engaging the person in the treatment and using collaborative decision-making processes (Dass-Brailsford and Myrick 2010). Trauma related questions should be included in the assessment of those presenting with substance abuse.

Integration has many challenges such as encouraging the person to 'own' both conditions. As many people do not acknowledge each disorder equally, some want to discuss PTSD and believe that the substance abuse is not really a problem while others recognise the substance abuse as a problem but are afraid to address the PTSD. Denial of many aspects of each condition is characteristic for those with a dual diagnosis (Najavits, 2002). Treatment is a crucial area and indeed a contested area for many clinicians, not only because of the severity of co-occurring substance abuse and PTSD but also a number of the treatments used for substance abuse or PTSD alone may be insufficient for their combined effects. Although substance abuse treatments have a much longer treatment history than PTSD models that are still in their (medically) early stages, each treatment has been developed often for particular groupings of people (Foa et al 2009). Some PTSD models of treatment have been developed for combat veterans and are based in Veteran Associations settings whereas women with PTSD have developed the conditions in quite different circumstances and it is logical to assume that a different model of treatment is needed. Likewise for substance abuse some treatments such as the 12-Step programmes which use mixed gender group settings and may be quite confrontational using the telling of stories in public etc, but may be quite



unsuitable for dealing with other trauma experiences such as rape. Gender-based groups may be an important consideration as they focus on the issues most pertinent to women or to men. Although an integrated treatment approach is generally the most recommended, research is needed to ascertain whether it actually out performs other approaches (Foa et al., 2009).

The '*Seeking Safety*' treatment programme (USA) is an integrated, coping skills model is notable because it was designed specifically for PTSD and substance use disorder (SUD) comorbid disorders. This model has been run in the USA for a number of different client groups. All the recent treatment models have a cognitive-behavioural foundation and focus on establishing safety and the development of coping skills.

This proactive targeting of a commonly co-occurring condition tends to be the exception rather than the rule, though research has recognised that some treatments targeting PTSD had positive effects for depression and general anxiety (Foa et al., 2009). There are several challenges to integrated treatment such as sufficient training of clinicians in assessing and treating comorbid disorders of PTSD and substance abuse; the comprehensive diagnostic evaluation preceding treatment; the complexity of the symptoms (complex PTSD) and how these impact on each other need; the monitoring over time of the person's PTSD symptoms and general functioning and, appropriate resources available for working with other health professionals, the person's family members and significant others (Foa et al., 2009).



Chapter 6

Methodology

The methodology was selected in order to meet the aims and objectives of the research and timescale. It included literature review and a set of semi-structured interviews with key managers and practitioners in the statutory, community and voluntary sectors. A number of key texts were identified by those who commissioned the research in order to establish the existing state of knowledge of comorbidity between post-traumatic stress disorder and substance abuse thus helping to identify issues and gaps in the current treatment for comorbidity. The Eastern TAP Coordinator established a Reference Group from a cross-section of Statutory and Voluntary/Community members on the Eastern Trauma Advisory Panel in October 2010. Monthly meetings have taken place with the Reference Group.

The researcher identified four areas of questions for the interviewees that could be developed, these were:

- practitioner's experience of treating people with PTSD as a result of the 'troubles'
- treatments available for comorbidity;
- integrated treatment approaches and sharing examples of good practice
- links with the 'other' sector, that is, the statutory links with the community/voluntary sectors and conversely the community/voluntary links with the statutory sector.

Six semi-structured interviews were completed with people working in the statutory and community/voluntary sectors. This information has been analysed to inform an assessment of the following issues:

- The extent to which comorbidity of post-traumatic stress disorder and substance abuse present complex and difficult assessment and treatment issues,
- Assess the effectiveness of an integrated treatment model and how this might be implemented across the sectors of interest.
- Identify examples of best practice assessment for individuals and how these might be most appropriately considered for an integrated pathway for victims and survivors/people affected by the 'troubles'.
- Identify the support needed to ensure people with comorbidity of post-traumatic stress disorder and substance abuse, receive aftercare to sustain and encourage the recovery of the individual.



Chapter 7

Research Findings; Analysis and Discussion

Content analysis was used leading to the development of themes which are reflected in the report. A series of six semi-structured interviews were carried out with key experienced people working in the statutory, community and voluntary sectors.

These were:

- Consultant Psychiatrist
- Trauma Counsellor
- CEO Substance Addiction Service
- Primary Mental Health Care Manager
- Senior Manager Mental Health
- Project Director Community based support Service

Interviewees were asked to share their experiences in four areas of their work:

- i) their experience of people 'presenting' with PTSD as a result of the 'troubles';
- ii) comorbidity approaches and treatments;
- iii) integrated treatment approaches including 'good' practice and links in the statutory and voluntary sectors with each other and,
- iv) share ideas of what they thought would be helpful to inform our understanding of trauma and comorbidity more widely.

1) People 'presenting' with post-traumatic stress disorder

A key finding was that trauma is not a heterogeneous condition and the interviewees shared both overall impressions gained over many years of how people 'presented' to them/their services and gave individual experiences to illustrate how varied the circumstances were.

The majority of people 'presented' in crisis often with a current situation that they were having difficulty solving. Some people presented with challenging behaviour that needed to be dealt with immediately,

"Some are presenting with high adrenalin, very jittery and needing a safe place, so one of the first things you need to do is create that sense of safety."

The sense of personal safety in both a physical and emotional sense was a recurring theme throughout the interviews. Several interviewees remarked on their experience with traumatised people being very sensitive to their environment when they came for counselling and the need to feel safe, for example, the room in which they met needed to have obscured windows. Many were also very reactive to the chaotic environment they were living in where violence, difficult relationships, rows and verbal abuse were common. Confusion was often the result and when people felt that they could no longer cope they turned to alcohol or drugs to numb the pain. Violence and 'acting out' became, it appears, a way to deal with the pain.

Although a single problem might be the initial starting point, there was usually a combination of issues that involved housing, benefits, job (or lack of one) and family difficulties. Sometimes people attended community counselling services under the 'cover' of bereavement. However it later became clear, through discussion, that bereavement was not necessarily the key issue. Bereavement, it could be argued, can be a socially accepted issue to attend therapy or counselling.

Young men in particular, are perceived as difficult to engage in therapies such as counselling; one reason identified was the macho culture in the community where it was not acceptable for males to talk about emotions or problems. Many young men in some areas of Belfast were living with anti-social behaviour threats, personal threats of violence and unpaid drug debts. These problems were often in addition to fairly chaotic family relationships and little stability in their home life and wider community. There was an



identified need to find ways of engaging with these young men as many of them had difficulties with 'severe dissociation' and were not ready to attend any kind of counselling therapy. Befriending for example, or some form of stabilisation that gives initial support until these young men are 'ready' to go to the next step seems to be the norm.

Post-traumatic stress disorder was often the result of an accumulative effect on the individual where previous traumas were re-experienced and many traumatic experiences impacted on individuals, families and communities. One respondent gave the example of a person who had attended counselling because of her son's suicide and his friend had committed suicide ten years previously. The mother was living in a society where her friends committed suicide as a way 'out of their problems' and she had had numerous deaths to deal with and unfortunately, this last one of her son was the one that catapulted her to counselling.

It is evident from the interviews that some people have experienced horrendous events, not only witnessing a murder or a friend committing suicide or a bombing but also being sexually abused by people close to them.

'Troubles' related trauma can sometimes be difficult to isolate because of the number of people who also experienced other traumas. Some people particularly those living in areas not only of high deprivation but also having suffered greatly from the 'troubles' experience multiple traumas, as one interviewee shared,

"Many people in this area have trauma after trauma after trauma and no one wants to talk about it".

However there is no doubt that it is a significant factor for many people presenting with PTSD symptoms. There are 'troubles' related traumas connected to the many years of shootings, bombings, deaths, injuries of the past as well as traumatic incidences more recently

in connection with, for example, paramilitary activity and influences, such as threats to young men who then have to leave the country for a period of time. As well as current traumatic incidences the interviewees talked about a significant number of people attending counselling in order to deal with incidences from thirty or forty years previously and only feeling 'safe' to talk about these past experiences at this time of relative stability in both personal and political contexts.

There was evidence of intergenerational trauma where children and young people did not understand what was going on in their family, and parents or grandparents being unable to explain their actions or come to terms with past life experiences. Community and voluntary services are experiencing an increase in numbers of people attending, one respondent stated,

"There are more people from the 70s and 80s coming to us now and they are experiencing a mid-life transition; they are disconnected with the young people coming up now, there is a crisis, young people don't understand where the trauma is coming from."

Interviewees agreed that the full extent of a person's trauma often did not always come out at the initial interview, as one stated,

"Sometimes you don't get it (their story) at once and I'm thinking of a man who had lost all interest in things and had stopped going out and he attended the sessions faithfully and it wasn't until his fourth session that something significant came out; his grandfather's death had affected him but there was also the death of a close friend that had affected him very deeply and he had not processed it."

Several interviewees talked of the complexity of a trauma that a small number of people experienced as they could be both victim and perpetrator; some had been traumatised because of what happened to them as a victim and they may also have been traumatised because of what they did as a perpetrator. For example, one said,



“Some people have been traumatised because of what happened to them as a victim and others have been traumatised by what they did to other people as a perpetrator, for example a young man who was involved in drug dealing on behalf of paramilitaries.”

People ‘presented’ in several ways, for some they found difficulty in dealing with a particular event in their lives; it may have been an incident in the past that they found hard to handle and dealt with this by taking small amounts of alcohol. This appeared to help them in the short-term though they found that this was not effective in the longer-term. Some people were referred to statutory or community services, often by GPs, because there was a concern about their alcohol consumption. Others presented with high levels of anxiety and/or depression and sought help with these conditions. Interviewees reported that sometimes a seemingly minor incident was enough to “tip them over sometimes”. Some people found the guilt relating to their feelings difficult to resolve, particularly when they observed others seemingly recovering, and they could not understand why they had not been able to ‘move on’.

However, not everyone experienced PTSD after a trauma. It was recognised that after some community incidences, where a high number of people witnessed a trauma, the majority of people seemed to recover after a relatively short period though a smaller number of others were more seriously affected. Although personal resilience was felt to be a factor that helped some people to overcome a trauma, others needed a high level of intensive support for a period. One interviewee felt that it could be argued that some communities gave strong support, acting as a significant coping mechanism. Whilst this may be a potentially fruitful area to explore in the future it was early days in terms of research that supported this assertion.

Definition of Trauma

There was some debate with interviewees about the definition of post-traumatic stress disorder and whether any form of assessment used to determine this such as DSM (Diagnostic and Statistical Manual of Mental Disorders) as published by the APA (American Psychiatric Association) had been used; there appeared to be no single or agreed form of assessment in either the voluntary or statutory sector. One interviewee asked for clarification about the APA definition of PTSD such as DSM-IV-TR and felt that post-traumatic stress disorder could be over or under-diagnosed; another’s experience was that it was members of the security forces - army, police or prison officers who were diagnosed and this may have been to secure compensation. Several interviewees reported that they were continually getting people referred to them who had undiagnosed issues and they felt that there was a need for diagnosis as this would assist to focus the treatment. A number of interviewees felt that a diagnosis would inevitably have resource implications in terms of treatment.

Whether the PTSD was diagnosed or undiagnosed the community support organisations reported that in their experience the majority of people that accessed their services had complex post-traumatic stress disorder. One respondent reported that,

“In this area the majority of people that have post-traumatic stress disorder are complex, they often have, but not always, a degree of dissociation associated with the PTSD. So that makes it particularly hard to address when they are chronically dissociating.”

Analysis and discussion

People live with a variety of traumas, often though not always, associated with the ‘troubles’. Whilst the experience of trauma varies from one person to another, the symptoms of post-traumatic stress disorder are common to all. As the literature reminds us, psychological trauma is characterised by feelings



of powerlessness, intense fear and rendered helplessness by an overwhelming force. People living with trauma symptoms tend to have challenging behaviour, they may attend counselling displaying high levels of anxiety or depression and they may exhibit outbursts of anger and confusion.

As the literature review indicates, the long-term psychological impact of the 'troubles' on the population requires more understanding (DHSS&PS, 2004) in terms of the consequences for general and mental well-being. The interviews supported this finding in that it is difficult to identify appropriate ways of dealing with post-traumatic stress disorder if there is no useful model that assesses this in relation to DSM (Diagnostic and Statistic Manual of Mental Disorders) criteria.

People often 'present' in crisis, this may be due to a single issue or several, perhaps a relationship breakdown, family difficulty, housing or financial problems. This is not surprising as the literature review suggests that the nature of trauma negatively affects relationships; the ability to concentrate; impairs interpersonal skills and can change how a person feels about themselves and their life. Many people experience dissociation, where there is a detachment of the mind from the emotional state, resulting in the person usually avoiding talking about the traumatic event and therefore finding themselves incapable of benefiting from support or guidance at the early stages.

Another way that people 'presented' was with substance abuse. This is a common coping mechanism for those who have experienced trauma. Coping strategies such as substance abuse may initially 'mask' the distress, as will prescription medication for symptoms such as depression and anxiety. There is evidence from the literature review to support this finding, in that the dual diagnosis of post-traumatic stress disorder and substance abuse has been found to be common regardless of the nature of the trauma or the substance used or misused (Breslau et al, 1998). The literature also

reminds us that in Northern Ireland dual diagnosis or comorbidity disorders are much more likely to occur for those who have experienced traumatic events (Bolton et al, 2008).

Living with violence and the threat of violence, both past and present is common for those attending the support organisations interviewed. Whilst there were many people who identified the need for trauma counselling as a result of a crisis, the research identified a need to find ways of engaging and supporting young men who are experiencing trauma and/or substance abuse.

We may suggest from the interviews that some people are affected more than others even when they have experienced the same or similar traumatic incident. The literature supports the finding that some people may seal away the after affect of some traumatic events for many years, even decades. This can be a self-defence mechanism 'kicking in' where the pain of the event has altered a person's consciousness of it. Some people were only able to talk about an event and acknowledge the impact it had on their lives when they felt 'safe' to do so. The unsealing of the trauma may occur many years after the event. The prerequisites of safety and trust are especially poignant in incidences of civil conflict where earlier research found that the events of the 'troubles' "still haunt the minds of many" (Dorahy et al, 2010).

It would appear from both the interviews and the literature that counselling provides an important means whereby people who are suffering from post-traumatic stress disorder can be supported to 'open up' and begin to understand how and in what ways this has affected their lives.

The research and literature identifies that when people are engaged in a counselling experience, through which they are guided and supported, they can name and begin to understand their current lack of resilience and/or well-being. The interaction with 'counsellors' opens the emotional Pandora's box which gives people



the opportunity, in a safe place and with someone that they trust, to articulate the past traumas as blockages to personal development and to develop, in time, the ability and courage to live creatively.

Current incidences of trauma may 'trigger' past traumas and the literature recognised the 'fragility' existing in many communities. It is also noted that where social and economic disadvantage is high there are correspondingly high rates of mental ill health, addiction, unemployment and conflicted related trauma.

However we should not lose sight of the fact that very probably many of the people affected by the 'troubles' live and come from areas of deprivation. One might suggest that the post-traumatic stress, from the 'troubles', may have been, or could be replaced, by other traumas associated with poverty and deprivation.

2) Experiences of Comorbidity – Post-traumatic stress disorder and substance abuse treatment and assessment issues.

Individuals from all the Services who were interviewed, both statutory and voluntary, had experience of people suffering trauma and using coping mechanisms, even if maladaptive, to assist them dealing with the trauma symptoms. Alcohol and prescription drugs were used as means of "*self-medicating*" and if there was a dual diagnosis, where a person was 'presenting' with suicide or a crisis then substance misuse appeared to be the self-medication used to subdue their feelings and emotional distress.

Alcohol was consistently the "*drug of choice*" and used as a blocker of memory or emotion. Quantifying the extent of alcohol abuse may be difficult though one statutory agency reported that approximately 50% of their service users were using alcohol. The interviewees' experience demonstrated that if high levels of alcohol dependency started, as a form of 'self-medication' it would lead to misuse, one said,

"... the people coming to me had experience of an event in their lives that was hard to handle and they would have a couple of glasses of wine or a few beers and it helps but not in the long-term."

Discussions with people about their use of alcohol as a coping mechanisms presented a number of problems, initially the person would often not accept that their intake of alcohol was particularly abusive or that they were misusing or dependent. There was also reluctance, as one interviewee found, to accept that alcohol was "keeping them from proper processing". The use of alcohol in many incidences was stopping people dealing with the denial and the guilt; it was being used as "a crutch" and it was also accelerating the difficulties, one interviewee found that in her experience that those with post-traumatic stress disorder,

"The trauma encouraged them to drink more."

This quote suggests that alcohol is the most accessible substance for people and that it is chosen for several reasons:

- easily available and licensing laws are more relaxed;
- it is affordable – statistics show that the cost of alcohol has decreased significantly over the past twenty years;
- a 'drinking' culture already exists – this may be associated with the family, friends, within the work place, for example, police/security personnel and within the community;
- it is an acceptable cultural 'norm' to drink and to, on occasions, have a 'blitz'.

One interviewee felt that the drinking culture was so accepted in Northern Ireland and that there was little agreed sense of what was acceptable or what was excessive. This has resulted in some people feeling that their drinking was "*not that bad*". Another interviewee's initial response to the question was to state definitively/categorically:

"Alcohol is very bad here (Northern Ireland)".



The same interviewee was also concerned that there was a progression from alcohol misuse that could lead to drug misuse – stating:

“Definitely, we have people with both; dual chemicals are a big issue in Belfast.”

Drug use/misuse

Most of the interviewees, statutory and voluntary, had experience of drug use as a coping mechanism with the majority aware of prescription drugs being used by people presenting with trauma. As with alcohol, prescription drugs were used as a means of dealing with emotions as a means of self-medication. As one interviewee reported,

“Our younger clients, who in most cases have been impacted by internal feuds or punishment from within their own community by paramilitary groups, usually will have already developed a problematic use of drugs which is accelerated after trauma.”

The key reasons given for the use of prescription drugs was the ready availability and historic use of, for example, Valium which was acceptable medication to be taking and in some cases was ‘passed on’ to others. In some communities, again those areas with high levels of deprivation, where many people had been taking the drug for a number of years and the dependency on the drugs needed to be recognised and addressed. One interviewee stated:

“Everyone was on these drugs for years and years and you can’t just come off them like that.”

Another interviewee felt similarly in terms of the link with areas of high deprivation and also emphasised that this problem was current:

“In terms of reduction in the problematic use of prescription drugs, on the ground we would still identify the ‘over prescribing’ of certain drugs as a

major factor of dependence, availability and problematic behaviours. I have heard that NISRA (Northern Ireland Statistical and Research Analysis) is looking at linking up prescription rates to areas of deprivation which might help show a link between communities with high trauma rates and high prescribing rates which I’m sure it will prove.”

Another interviewee felt that the prescribing of drugs was being reduced:

“Overall there has been a 7% reduction of (prescription) drugs, mainly due to more awareness with GPs, costs and Mental Health Nurses particularly with the Bensedrine drugs.”

For several interviewees their experience was, in the recent past, an acceptance “of handing out Valium and GPs prescribing this” and that this was the way many people coped with the ‘troubles’ and the trauma they experienced.

Treatment approaches for comorbidity

Comorbidity was recognised as a complex issue and all the Services found that dealing with it was a challenge. Some people could not deal with the trauma while they had severe addiction problems whilst others could not deal with the addiction problem because of the trauma. The consensus amongst the Service providers was that treatment was “not linear” but was more, “depended on how the person ‘presented’.”

Dual Diagnosis

The term ‘dual diagnosis’ is used to describe the comorbid condition of an individual who has two separate, though very interrelated diagnoses. It is often used to describe the comorbid condition of a person who is considered to be experiencing a mental illness and a substance abuse problem. There are guidelines for dual diagnosis; the NICE (National Institute for Clinical Excellence) guidelines are followed in the statutory sector.



Therefore the need to address the dual diagnosis of substance abuse, whether alcohol or prescription drugs, was felt by all the interviewees as necessary in order to deal with the trauma related symptoms. Some preferred a sequential approach and others strongly advocated an integrated approach where both conditions were treated at the same time within the same organisation or with another organisation that was known to them. For example, one respondent said,

“This (dual-diagnosis) is very common and shows how important it is actually to have a good assessment in comorbidity issues when you are actually setting out, looking at the person needs to have the alcohol or the drug issues sorted. Both these two strands need to go together... they cannot be separated out ...and that the person actually contracts to do that right from the word go.”

There was recognition that medication may be needed to deal with symptoms such as suicide thoughts, sleeplessness and depression in order to stabilise the person and ensure safety. Occasionally a limited use of medication was accepted as useful for a short-term, one stating,

“We will work on reduction and abstinence. It is only through a journey of treatment that you get an understanding of mental health assessment, for example, post-traumatic stress disorder, family relationships breaking down, unemployment etc.”

Having a specialist team on site that can deal with the addiction problems was felt to be a necessity particularly when dealing with more severe cases of dependency. Treatment for alcohol misuse, for people suffering from trauma, was available in both statutory and voluntary services although there were differing approaches as to whether the alcohol abuse (misuse and dependency) was treated first and separately, or was integrated into a holistic treatment

plan for the individual. Sometimes the specialist team was part of another service, for example the Community Addiction Team or Mental Health Team and there needed to be a referral to this team although, for others the specialist staff, dealing with addictions, was an integral part of the same organisation.


Assessment Issues

Assessment for comorbidity was not consistent across the statutory or voluntary sectors. Therefore prior to undertaking any assessment all those involved will need to clearly define what they mean by post-traumatic stress disorder and substance abuse. There could be a variance in terms of the GP that a person attended and the way the person 'presented' to the GP for example whether they identified depression, substance misuse, self-harming, high anxiety, aches/pain, loss of appetite etc. There may also have been bereavement in the family or other social factors such as job loss, relationship difficulties, feelings of worthlessness etc. Community Addiction teams and Mental Health teams also referred people that they had concerns about to specialist services.

However it should be noted that in the voluntary/community Services a significant number of people self-referred.

Most services had their own assessment, which tended to be a written, *Assessment or Consultation Form* that the person completed with a staff member, usually a counsellor. The assessment of a person attending the service was felt to be necessary for two reasons, firstly it was important to assess risk and secondly in order to have sufficient information so that the person could be referred to the appropriate service. One respondent says,

“There is a risk assessment involved in regard to suitability to suicidal tendencies, drugs and alcohol. We do an assessment and they get allocated to a counsellor and the counsellor sees



them and as we are open ended we see them as long as the counsellor deems necessary.”

The information gathered using a form is aimed at obtaining an overview of the person and their current issues and from this information it is possible to create a treatment plan. Occasionally someone may be assessed as unsuitable for counselling as this response demonstrates,

“The first assessment is to see if the person presenting is ready for counselling, and, occasionally we have had to say ‘no they are not’.”

Several organisations recognised that some people were not at the stage of being able to talk about their trauma, though they may have approached them for help. In these instances the organisation will complete a “*motivational interview*” and then identify a suitable starting point for these person, as one counsellor states,

“If the person is not ready then we carryout the motivational interview, the counsellors do this and then make an assessment of what might be the most appropriate place to start.”

Overall the statutory and voluntary organisations strived for the best possible way to carry out an effective assessment of a person presenting with post-traumatic stress disorder and/or substance abuse and used this information as the basis of deciding on the most effective treatment.

Testing and Tests

During the research interviews there was some discussion about the area of testing and who carried this out. One interviewee raising the issue that,

“Counselling traditionally does not do a ‘battery of tests’ and one of the reasons for this is because it is drummed into counsellors that they do not furnish a diagnosis”.

Whilst this may be the case, there was a pragmatic approach taken in that it was necessary to ascertain whether a person was experimenting or dependent on alcohol, or had high anxiety or depression. The assessment measurements mentioned as being used by the interviewees were CORE systems forms for therapeutic assessment, AUDIT (Alcohol Use Disorders Identification Test) and “if there is anxiety we use the HADS (High Anxiety Depression Scale) but if more serious usually CBT (Cognitive Behavioural Therapy) or referral to a Psychologist who might use EMDR (Eye Movement Desensitisation and Reprocessing).” *Several voluntary organisations recognised the need for “medical help with assessment, if there are underlying mental health issues”.*

One interviewee emphasised that the assessment tests were not for diagnostic purposes, as psychiatrists would do, but for reasons of offering the appropriate support. Another interviewee talked about “a ‘light touch’ if there is anxiety or PTSD” emphasising that sensitivity is used.

Analysis and discussion

Alcohol and/or prescribed medication can alleviate many of these symptoms, at least, in the short-term. People may find that they are more relaxed and able to manage social situations more comfortably having taken alcohol. There was evidence in the literature to support the fact that people are often in denial about the amount of alcohol they are taking and about their dependence on alcohol to perform everyday tasks. Alcohol use usually leads to two problems, those of misuse or dependence and can affect the whole family adversely (Murphy et al, 2005 cited in NICE).

Some prescribed medication can ease anxiety and depression and help to create some sense of equilibrium thus managing the extremes of behaviour. Previous research informs us that alcohol use is generally accepted in this society and that it is easily available and relatively inexpensive. It might be argued that alcohol is easier to obtain and



perhaps more acceptable than prescribed drugs, however there is evidence that prescribed drug misuse is common in some areas and social groups.

Comorbidity entails a number of problems; in the case of post-traumatic stress disorder and substance abuse, there are two conditions 'playing off' each other. The presence of additional disorders indicates a more complex clinical presentation as this will have several targets for both assessment and treatment according to the literature. The comorbidity of post-traumatic stress disorder and substance abuse is described in literature as a 'downward spiral' where trauma symptoms are common triggers of substance use, which in turn can heighten post-traumatic symptoms (Najavits, 1997).

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

The person's readiness for treatment, such as counselling, is recognised in the literature as a pre-requisite for positive engagement in treatment. However some people are not ready to talk about the trauma. One factor may be the climate of fear created by the context of civil conflict resulting in limited opportunities for those affected by the 'troubles' to 'tell their story' thus limiting the acknowledgement of the impact of their trauma, and the great difficulties of identifying who they could trust – if and when they opened up the dialogue (Bolton, 2008).

As Herman (2001) reminds us that the effects of complex post-traumatic stress disorder are such that they impact on the inner core of self-structure and

destroy the person's fundamental assumptions about safety in the world.

Comorbidity means that there is a complexity of issues being dealt with by both the person experiencing the symptoms and the support service. The literature emphasises that the presence of additional conditions, as there are in comorbidity, (where there is a dual diagnosis of post-traumatic stress disorder and alcohol or drug abuse) will indicate a more complex clinical presentation that has several targets for both assessment and treatment. A comprehensive assessment for PTSD must therefore include an evaluation for comorbidity, thereby determining any other conditions that may be present. An appropriate treatment plan that prioritises the conditions can be developed.

Whilst it was recognised by all the Services that treatment for both conditions was necessary, there were differences in whether to take each condition in sequence, starting with the substance abuse or treat both the post-traumatic stress disorder and the substance together in an integrated treatment plan. There was evidence to support traumatic syndromes having basic features in common and the recovery process was assumed to follow a common pathway. However others believed that the very complexity of the disorder or condition presents multiple targets for both assessment and intervention (Weathers, Keane & Foa, 2009).

The literature also reminds us that complex PTSD presents more severe symptom profiles especially around self-identity and relating to others, and demonstrates more vulnerability to self-harm (Herman, 2001).

Assessments were carried by all the Services though the content of information was inconsistent. This variance is probably not unusual. Identifying appropriate referral agencies was often difficult when there was a dual diagnosis. Treatment could 'fall between two stools' of psychiatric Services and drug



and alcohol agencies. Furthermore the literature found that the majority of people with comorbid symptoms of PTSD and substance abuse did not receive an assessment for trauma when being treated for substance abuse, and similarly were not assessed for substance abuse when being treated by some mental health clinicians (Najavits, 2008).

Whilst a common assessment form used by all the Services could be useful for people diagnosed with either PTSD or substance abuse conditions, we know from the literature review that there is still some debate around whether the PTSD is primary or secondary to comorbid disorders such as depression or substance abuse, and whether the treatment of PTSD will lead to an improvement of the comorbid condition. However there is an agreement from both the interviewees and the literature that a thorough assessment is always advised as the treatment plan is very dependent on this being carried out.

The impact of post-traumatic stress disorder has been so severe for many people attending the Services that they needed to find ways of coping with the symptoms. There was a need to ease or 'block out' the intrusive flashbacks that they were unable to control; they needed to be able to rest and sleep and be able to engage with friends and family; feel safe and cope with everyday situations. Many post-traumatic stress disorder sufferers may not recognise that their distress has a name. Some might be reluctant to admit they were experiencing any form of distress perhaps due to fear and associated stigma of mental illness, or they may feel that – if others have 'got over it', why they have not? The interviews reveal that people 'present' in different ways, for example with depression, anxiety, alcohol or drug problems, somatic and sleep problems or bereavement. The person experiencing trauma may not relate their symptoms to the traumatic event, especially if a significant time has elapsed since the event, or they may attribute the symptoms to a less significant event. It may not be obvious to the person that they are experiencing post-traumatic stress

disorder, or to the fact that the immediate and short-term impact of a traumatic event is fear and shock resulting in numbness and a failure to fully process what has happened. The literature defines PTSD as a complex, often chronic and debilitating mental condition that develops in response to a catastrophic event and therefore it is unsurprising that many people are unable to identify the problems (APA, 2000).

Post-traumatic stress disorder is, as has been stated, complex with the three symptom clusters of intrusion – a re-experiencing of the trauma; hyperarousal – a permanent state of alert and constriction – numbness and detached, and all these symptoms have a significant affect on the person's ability to function. According to Herman (2001), people vacillate between the extremes of amnesia of the event at the same time reliving the trauma. There is often a strong desire to avoid talking about 'the' trauma often resulting in people tending to keep details of the event, their reactions and intrusive thoughts etc secret. It is understandable therefore for people to seek ways to alleviate the distress caused by these symptoms in ways that are more short-term rather than seeking professional help to deal with their issues in the long-term.

3) Integrated treatment approaches and sharing examples of 'good practice'

There appears to be an acceptance that an integrated approach or Service that meets the needs of people suffering post-traumatic stress disorder was the most appropriate way to treat people. However the term 'integrated' needs to be defined. There were a number of interpretations of an integrated treatment approach could work in practice, for example in terms of client management and with parallel or integrated services verses referrals to existing community services. Some voluntary organisations felt that they were able to offer an integrated service as few already offered counselling



services for trauma and addictions. Some also offered additional services such as

“complementary therapies, mentoring, befriending, parental substance abuse support groups, action-based opportunity programmes and welfare advice.”

All the interviewees saw the merits in taking a holistic approach in treating people with a dual diagnosis and recognised the need for social support, family support (where possible), befriending, assistance in getting a job, help with housing difficulties and the benefits of various community support/interest groups and faith-based organisations. One interviewee’s experience was that,

“Social support is good for prevention and social support is good for recovery.”

Person-centred

Keeping *“person-centred”* was central to the services offered and a number of interviewees talked about treating each person as an individual and finding the means to support their needs,

“We individualise the person, find out what is wrong and wrap the services around them.”

Another felt that

“There shouldn’t be a ‘wrong door’ it has to be a much more fluid process.”

One interviewee had recently travelled to the USA where she visited a programme, which had a service that integrated statutory community and voluntary services and had complementary therapies, GPs, counsellors, all in the same building. Case conferences were held for all clients along with discussions on their treatment and progress. This approach was, she felt, an effective way of managing the needs of people with post-traumatic stress disorder.

The importance of encouraging people with trauma to engage with others in the community and to talk about their experiences was emphasised as an effective strategy for many who were experiencing post-traumatic stress disorder. However everyone recognised that the recovery process took time and in cases of complex PTSD more was needed in terms of resources and services.

Safety in accessing Services was an issue and whilst some people would access statutory Services regardless of where these were located, it was felt that many others would only attend services located within their own community. Those attending Services in, for example Lisburn would be unlikely to attend locations in Belfast or in communities that were perceived as ‘the other’. Community based voluntary organisations felt that there was strength in their Services being locally based, easily accessed e.g. offering a self-referral system, better understanding of peoples’ needs, ex-prisoners and are able to respond to a community crisis or incidents “quickly”.

The person’s ‘readiness’ for treatment is a key issue; the person should understand and agree with the treatment plan and if they do not the Service is unable to support them effectively.

Increased resources for an integrated service may be a factor as dealing with trauma and related comorbidity issues means that a range of resources are needed to tackle what has been identified as a “complicated issue”. However if there are additional costs, these could be assessed against current relapse rates. There appears to be an aspiration to provide an appropriate integrated package that draws on the strengths of both statutory and voluntary Services whilst at the same time is flexible enough to meet the often challenging needs of comorbidity.

One interviewee cautioned that it was early days as yet in terms of treatment approaches and that little



research was happening in Northern Ireland; they felt that government was not encouraging research and that “... when some research has been done the government hasn't liked what it has said”

Good practice in treatments for comorbidity

The need to create a sense of safety for the person was a key aspect for helping to stabilise a person and this was not necessarily a quick process but would generally take time,

“... so you start to support the person, develop trust and safety as the first point – it is fundamental really.”

The experience of some interviewees was that women would often retreat into themselves and deal with issues such as low self-esteem and internal blaming, while others may need to deal with anger issues. Several interviewees discussed experiences of dealing with self-harm and suicide as these tendencies had to be addressed as a matter of urgency before any counselling or treatments could begin. For example, one said,

“If you can raise their level of stability within the community then you have had a success. I am a very practical human being and you get ‘it’ (life) as good as you can get it for a client and that does not mean you have them cured and that they go through the whole process. You get them to wherever they can cope.”

Depression

For some depression was common and needed to be addressed. One interviewee observed that a number of people could become self-absorbed and needed support to move beyond the depression,

“People get so maudlin with thoughts of ‘why am I still here?’ They were still thinking about that death etc. So the person needs to get to a stage of readiness, guilt is a big factor – and then try to get people to realise that everyone copes in

different ways and that they need to process it – it doesn't go away until it is processed.”

Most of the interviewees recognised that for some people the journey of recovery would be very difficult, “... some people cannot talk about the trauma ... it is simply too painful” and in these cases a journey of building trust and a sense of safety was the starting point.

Safety and trust

Trust in the counsellor and the service being non-judgemental were issues raised by several voluntary organisations. Some people needed to establish safety as a matter of key importance due to the nature of their trauma being ‘troubles’ related.

It was evident that all the interviewees reflected on their practice, they carried out evaluations and listened to what users said about the Services they received. Voluntary organisations had carried out a number of evaluations as part of their organisational practice regardless of funding requirements.

The Statutory Services talked of referring people to Community and Voluntary Services and of the importance and effectiveness of these services.

Some examples include:

- befriending Services at Praxis;
- aromatherapy at FASA;
- skills-based training at New Horizons e.g. Tiffany Glass making;
- substance misuse counselling at FASA;
- training/classes at ACCEPT and ATLAS;
- external counselling services provided by WAVE and Contact Youth;
- NIAMH and Mulholland Aftercare Services;
- Suicide Awareness group.

Voluntary organisations discussed several programmes that they felt were effective, for example the ‘Cycle of Change Programme’ (FASA) and the ‘Who Am I?’ therapeutic intervention course offered at the Ashton Community Trust. There was also



some discussion on models of care including the 'Seeking Safety' programme as pioneered by Najavits. One respondent talked about the need for short stay respite in a non-medical environment and highlighted two places offering nurturing and non-judgemental support and space to reflect, rest and restore hope for those who are despairing - Pieta House (Dublin) and Maytree House (London) – they felt would be valuable approaches to explore further.

Analysis and discussion

Creating an environment that encourages a release of the problems that are part of the legacy of the 'troubles' is not simple. The literature reminds us that there is much evidence supporting the damaging psychological effects on large numbers of the Northern Ireland population as evidenced by high rates of mental health problems, injuries from shootings and bombings, even if there is a lack of psychological research that uses psychometrically sound measurements (DHSS&PS, 2004). It is recognised from the research and from the literature that the provision of a safe, supportive and trusting environment is essential for people to seek help and address the issues causing their distress and substance abuse. It is also, argues Herman (2001) part of the healing process in that recognition and restitution are needed in order to rebuild the 'survivors' sense of order and justice.

The research findings and the literature remind us that comorbidity leads to the person's problems being compounded. Appleby (2004) in the National Service Framework for Mental Health report recognised that Services for people with a dual diagnosis are the most challenging clinical problem that is being faced. The complexity of issues makes the diagnosis, care and treatment more difficult as people are at higher risk of relapse, readmission to hospital and suicide.

The importance of keeping 'person centered' and having identified the problems, Services needed flexibility and the ability to provide the appropriate

treatment at each stage of the recovery process, taking account of the biological, psychological and social components of the disorder (Herman, 2001).

We know from the literature that there are four main treatment approaches to comorbidity, these are:

- 1) *integrated* where clinicians treat the conditions at the same time and use the same provider;
- 2) *sequential* where the approach is to treat one condition then the other, often substance abuse is deemed necessary to treat prior to the treatment for post-traumatic stress disorder;
- 3) *parallel* or concurrent where each condition is treated separately and by different providers such as Mental Health teams dealing with trauma and Addiction teams dealing with substance abuse and lastly
- 4) *single* diagnosis where only one condition is treated.

Although there is some debate as to whether the trauma symptoms have common pathways or whether the very complexity of comorbidity conditions presents multiple targets for intervention, there is agreement for having flexibility and a number of entry points in any Service supporting those with comorbid conditions.

The research findings confirm that treatment for comorbidity is not a linear process and that many people experiencing trauma have on-going crisis in their lives. Starts and pauses in their treatment may be characteristics and indeed may be the only way that people are able to engage in the process of change. The difficulties for people dealing with post-traumatic stress to confront the feared and often avoided memories of that trauma should not be underestimated. The personal experiences cited in the literature remind us of the overwhelming feelings of shame, guilt and anger and how little energy or motivation there is to address their own needs. Many people may not even recognise that their distress has a name.



A key feature of recovery is to establish safety for self in relation to the threat or terror that the traumatised person is experiencing. This may refer to a place of safety as well as being supported to feel safe 'in their bodies' given their emotions and their thinking is out of control (Herman, 2001; Foa et al, 2009). The focus of the intervention therefore, in relation to the last point, is to establish a pattern of eating, sleeping and exercise so that the body is into a health promoting rhythm. Through establishing safety and protecting the individual, the management of both the post-traumatic stress symptoms and the control of destructive behaviour is achieved. Herman (2001) goes as far as saying that no other therapeutic work should be attempted until a reasonable degree of safety has been achieved.

The research emphasises that traumatic life events invariably cause damage to relationships and although people with post-traumatic stress disorders have survived the event, their levels of trust in people are often extremely stretched. Bolton (2008) found in his research that the building of trust is a crucial issue for those experiencing post-traumatic stress disorder and that therapies should be characterised by supportive and trust building measures. Herman (2001) proposes that an effective and sustaining treatment approach is to empower the person suffering from post-traumatic stress disorder. She advocates what she terms as "the convergence of mutual support with individual autonomy" thus suggesting that the therapist places all their knowledge, skills and resources at the person's disposal. The role of the therapist is crucial in assisting the person by presenting choices and working as an ally; the advantage with this approach, she argues, enables the person to begin to make decisions and gradually take control in their lives. Thus suggesting it is central to the recovery process for the therapist to work on the principle of restoring control to the person.

The need to recognise the complexity of the psychological, physical, emotional and social problems that arise with comorbidity diagnosis is important in order to support the person. Identifying the needs of the individual and ensuring that the treatment plan meets the level of support required is the starting point for all Services supporting those presenting with comorbid issues. There was a consistent message from the research that an integrated approach best suits the treatment of comorbid conditions. Treating both conditions at the same time is recommended by clinicians and supported by research as being more likely to succeed. It was argued that it was also more cost effective as there was a higher likelihood of the person not relapsing. Currently the relapse rate in Northern Ireland mirrors that globally, and is one third of people relapsing fairly quickly and another third relapsing some time later.

Whilst it is still relatively early days in terms of evidence from clinical trials addressing comorbid conditions that occur with post-traumatic stress disorders, there seems to be a number of promising treatments with positive outcomes developed in the past five years and reviewed by Foa et al (2009) in their practice guidelines. The 'Seeking Safety' model as developed by Najavits (2002) takes an integrated approach and is designed for post-traumatic stress disorder and substance use disorder appears to be one of the most researched models of treatments, in America, that has highly successful outcomes.

4) What is helpful to inform sharing practice and philosophy about trauma and comorbidity?

All the interviewees agreed that there was a great need for psycho-education both within the community; for family members and for individuals who were experiencing trauma and substance abuse. Several people mentioned the need for education such as awareness-raising and the need for booklets. Written information, they felt, needed to be conscious of literacy levels and the fact that



individuals absorb information in different ways, for example,

“For one person it would be a story that would really impact on them, for another a leaflet with very clear bullet points would really hit them between the eyes. Whatever it is it has to be relevant and it has to bring the key factors together.”

Several interviewees felt that more information on trauma; what it is and how it affects people would be helpful; there was also a need for families, *“usually a huge force for good”* to have more understanding of trauma in terms of how it affected the individual experiencing the trauma, what issues they could expect to be dealing with in the family and a sharing of coping mechanisms that families would find useful.

Interviewees felt that there was a need for further understanding of how alcohol affects a person who is experiencing trauma. The fact that alcohol is a depressant and that far from alleviating trauma symptoms, it may make the symptoms worse. One of the effects of trauma is that most people have difficulties with concentrating thus leading to the inability to take in information and connect this to their own symptoms. Living in a fairly chaotic situation results in many people failing to see patterns of behaviour that are harmful, as one interviewee reported,

“They don’t connect it up and you get this crack because of the trauma they are living in and chaos they are living in they don’t connect things up. So there will be a pocket of knowledge here and a pocket there but there isn’t a holistic knitting together or the understanding of the pattern that happens.”

The comorbidity of post-traumatic stress disorder and substance abuse often results in people developing maladaptive coping strategies and when a person is in pain and at the same time their world closes in on

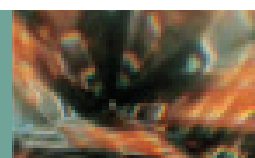
them. This is where information that uses few words yet is clear and brings relevant factors together is much needed.

More recognition by the Government of the research linking high levels of alcohol related deaths in areas of high deprivation, the higher risks for males of suicide along with resources to tackle their reluctance to engage with therapies was felt to be important. The very high levels of prescribing tranquillisers in Northern Ireland as compared with other parts of the UK and Europe needs to be addressed and resources made available to reduce dependency and to break the intergenerational legacy that is prevalent in areas of deprivation.

The perceived lack of strategic planning that is long-term and sustainable was felt to be a weakness in regards to informing the area of trauma more widely. The Community and Voluntary sectors felt this particularly strongly as they tended to have a more difficult task in raising funds to sustain their Services. Examples were given where a voluntary organisation responded to a community crisis yet received no additional funding and of the precarious nature of ‘year on year’ funding that resulted in longer-term strategies being difficult to consider. Community and Voluntary Sector consultations were felt by some in the Voluntary Sector to be ineffective, as they were not focused enough on the effectiveness of existing Services. It was felt that useful information could be gained if existing Services were asked to analyse their current usage, identify the challenges and trends in the work.

Analysis and discussion

A question arises about people with post-traumatic stress disorder having the ability to ‘see’ the problems, and the simple answer is probably not, at least initially. The literature reminds us that post-traumatic stress disorder is a serious psychological condition following exposure to real or threatened bodily harm (APA, 2000). Consequently the physically traumatised body is not a normal body; it



lives in a constant state of terror and when the body is traumatised instead of attacking or retreating it tries to do both at the same time, thus swinging between two extremes. This is why those who exhibit these behaviours can be so erratic and change quickly causing instability and further exacerbating the traumatised person's sense unpredictability and helplessness (Herman, 2001).

The literature suggests that the family and friends may become bewildered, distressed and find difficulty in being supportive when a family member coping with trauma. If they are informed about the nature of comorbidity and the likely symptoms, then the evidence is that are prepared and far more able to tolerate the disruptions in their lives.

Psycho-education has a role to play in understanding the connections between post-traumatic stress disorder and substance abuse. It is very important to know that the most common coping strategy for those affected by trauma is to use substances such as alcohol and prescribed medication to ease or

numb the pain of the trauma. This also tends to 'mask' the distress. Depression can be compounded by the use of drugs or alcohol that may have been taken initially to alleviate anxiety and to help reconnect with people. However the misuse of alcohol and/or drugs may produce similar numbing effects because traumatised people are unable to spontaneously change the numbing or detachment effect until they have processed the trauma. The general public, family and friends may be unaware of the prevalence of physiological health problems such as pain, anxiety attacks, chronic fatigue and self-harm and suicide risk that people with a comorbid diagnosis experience. Many turn to using alcohol, drugs, caffeine or nicotine in order to cope with their symptoms and this may eventually lead to dependence on these substances. Substance abuse affects not only the individual who has been traumatised but may also affect the whole family and include the community. This situation would support the need for a community education strategy that may also aid recovery.





Chapter 8

Conclusions

This research has provided an insight into many of the issues concerning and relating to trauma and substance comorbidity. The review of literature has given a comprehensive picture of the nature and effects of post-traumatic stress disorder on the individual thereby assisting those involved in the provision of support and treatment.

- It is clear from the research findings, the review of literature, the analysis and discussion that trauma and alcohol and drug comorbidity is a complex and challenging issue. The investigation into issues associated with post-traumatic stress disorder in terms of individual trauma, agency responses and community involvement has indicated that there is much knowledge and understanding and some current, but sporadic, good practice in terms of interventions.
- The 'troubles' have left a large legacy in terms of individual and community health needs. Studies have shown that people most directly affected by the 'troubles' are more likely to experience poor mental health with figures for Northern Ireland approximately 25% higher than in England and Scotland. There is evidence to support the fact that some communities have disproportionately borne the brunt of 'troubles'-related deaths, injuries and violence and that these same areas also have high levels of poverty and ill health. The Belfast Drug and Alcohol Working Group, comprised of the key statutory, voluntary and community organisations with a remit for, or interest in, tackling substance misuse in the Belfast area, has been undertaking a scoping exercise into drugs and alcohol service provision across the city. The group has identified gaps and issues across a number of areas and has developed a report with recommendations to be considered by those with a commissioning and co-ordinating role for such services (June 2011, 'Scoping Report On Drugs and Alcohol Services/Work In Belfast Prepared By The Belfast Drug And Alcohol Working Group')
- The effects of current and intergenerational trauma, addiction and poverty impacting on individuals and communities needs to be acknowledged and addressed by government. The Department of Health Social Services and Public Safety will need to gain further evidence, using validated instruments that assess post-traumatic stress disorder in relation to Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM 1V) criteria in order to identify the long-term impact and needs of the psychological impact of the 'troubles'.
- A key issue for the Health Services, statutory and voluntary, is the variety of ways that people with a dual diagnosis of post-traumatic stress disorder and substance abuse 'present'. This is complex as the two conditions are 'playing off' each other and people tend to 'present' in a variety of ways, for example, substance misuse, addiction, somatic symptoms, anxiety and depression. People are often 'presenting' in crisis and specialist skills are needed to deal with a range of needs such as addiction, self-harm, depression, anxiety and social or family relationship difficulties.
- The importance of a comprehensive assessment carried out by suitably qualified staff is emphasised in the research as this provides the basis for an appropriate treatment plan. The treatment plan should be person centered meaning that each person is treated as an individual and that there are resources found to support their needs. This approach might be well summed up by the phrase from one interviewee whose experience was "to wrap the Services around them".



- People living with trauma and substance abuse symptoms require a great deal of support as they often display challenging behaviour and this makes it difficult for family, friends and other supporters to comprehend. The research confirms that people are often unaware of what has happened to them in terms of the effects of trauma; they are unaware of the effects of shock, erratic behaviour, difficulties in concentration and withdrawing from people that they were close to. Psycho-education therefore has an important role to play in ensuring greater understanding and keeping good support mechanisms functioning well. It is equally important that the person is also supported to learn and understand more about the effects of trauma and substance abuse on their biological, psychological and social well-being.
- Treatment for comorbidity is not a linear process. Trauma affects people in many different ways and 'readiness' for treatment is a major factor in the positive understanding and agreement to take part in a treatment process. The need to establish safety (this may include physical, emotional and psychological safety) for the person affected by trauma is a pre-requisite to any other therapeutic work.
- Alcohol and prescription drug addiction or misuse is often used as a coping mechanism to ease trauma symptoms. This form of 'self-medication' can be more easily understood when the person's awareness of the two conditions is increased. The empowering of the person through their treatment is an effective and sustaining treatment approach that seeks to address the feelings of powerlessness that those with post-traumatic stress disorder experience. The role of the therapist is crucial in assisting the person to find a focused based treatment.

- An integrated treatment approach is recognised as having much to offer in the treatment of comorbidity. However this treatment approach is in relatively early stages and it may be important that a definition for integrated treatment is discussed inclusively and agreed by all the Services involved. There is a high level of expertise in the fields of trauma and addiction and this should be well served by best practice.

Further Issues

The analysis of the research has provided a number of questions. There are major issues about acknowledgement, understanding and resources for post-traumatic stress disorder.

Further research may address the following questions/issues:

- 1) How do Services create an engagement with people that they feel need help?
- 2) There are additional issues of deprivation and poverty and how these impact on comorbidity.
- 3) There appear to be issues for 'joined up' thinking between the Statutory, Community and Voluntary current providers.
- 4) There is a need to build on what is obviously good practice from professional clinicians both locally and abroad.
- 5) The need for an obvious knowledge base to inform the development of a good practice base.
- 6) At times it appears that if trauma is going to be dealt with, the individual will need to recognise it and take part in a 'healing process' notwithstanding the issue of opening what has been referred to as the 'Pandora's' box.



Chapter 9

Recommendations

- 1) An Interagency Working Group to be established that would consider the findings and recommendations of this report and identify further actions, for example, an action research project on comorbidity.
- 2) The reaffirmation of the link that trauma, alcohol and drugs comorbidity should be expected, that is, where there is substance abuse there might be trauma; which relates to the 'troubles' and comorbidity.
- 3) As comorbidity is a diverse group with complex needs, there should be a strengthening of referral pathways and capacity for collaborative care management. Staff from the statutory, community and voluntary sectors could benefit from joint in-service training.
- 4) A skills audit could be carried out in order to assess the staff competency in assessing and treating comorbidity with the ability and understanding to assist people with these complex needs.
- 5) A mapping exercise of available treatments in the community, voluntary and statutory sectors and some quantification of the outcomes.
- 6) The Eastern TAP is well placed to utilize the learning from this research to produce a psycho-educational resource for individuals, family members and wider society so as to increase awareness and understanding in the community.
- 7) In order to contribute to best practice a Task Group could be established to explore theoretical and practical trauma training to improve assessment, treatment and management across the statutory, community and voluntary sectors.
- 8) Further research, prompted by Eastern TAP to provide a robust longitudinal evidence base about the efficiency and specific outcomes of an integrated Service provision.
- 9) Further areas for possible literature review or research include –
 - the support needed for families of those who suffer from comorbidity;
 - a study of gender difference and how this could define the therapeutic intervention;
 - an examination of other therapies such as complementary therapies, art therapy and models from other societies;
 - more detailed research on the nature of addiction.
- 10) The Eastern TAP could host occasional 'best practice' research symposiums to ensure wider dissemination and recognition of this comorbidity.



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