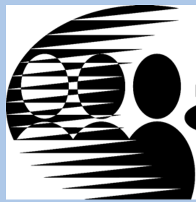

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RESOURCE LINKS

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TRAUMA, TERRORISM AND SUBSTANCE ABUSE

INTRODUCTION

The content of this bulletin summarizes recent literature presented at the National Summit, When Terror Strikes, sponsored by the U.S. Department of Health and Human Service Substance Abuse and Mental Health Services Administration in New York City, November 14-16, 2001.

Traumatic events that occur at a national level can act as an important catalyst to mobilize our thinking, but can also lull us into thinking that such an event will not significantly affect us as individuals. Traumatic events come in many forms characterized by fixed (time limited), or prolonged time frames. A population's response to trauma will vary by characteristics such as: the type and degree of exposure, geography, the available system of medical and psychosocial supports. Individual characteristics that are associated with different responses to a traumatic event include the degree of exposure to the event, individual physical and mental health vulnerabilities, gender and educational level. The most common mental health problems that significantly increase in response to trauma include:

- Post-traumatic Stress Disorder (PTSD)
- Major Depression
- Generalized Anxiety Disorder
- Substance Abuse Disorder (new cases, exacerbation of current cases, and relapse of remitted cases) and
- Phobias (Brown, et al. 2000)

Increased alcohol consumption often occurs following major trauma events (Bravo,et al.,1990). It can be presumed that increased consumption will lead to abuse and dependence. During traumatic times, counselors need to look for the above.

What is PTSD?

According to the American Psychiatric Association's definition, PTSD is a result of a traumatic experience that causes intense fear, horror or feelings of helplessness. Diagnostic criteria also include symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms and hyper-arousal symptoms. To meet a clinical definition of a disorder, symptoms must last for at least one month and may appear immediately or after a long delay, sometimes even years (Harvard Mental Health Letter, January 2002). The lifetime prevalence rate of PTSD is between 9-14% (Bresslau, 1991; Bresslau, 1997).

Males are generally more at risk for exposure to trauma, but females are more at risk for developing PTSD. Being exposed to one type of traumatic event was associated with psychological distress but, being exposed to multiple types of trauma was associated with lower psychological distress.

PTSD is often exacerbated by the effects of pre(female gender, previous trauma), peri(horror of trauma, threat of death) or post(physical injury caused by trauma) risk factors.

Specific risk factors that lead to developing PTSD following exposure to trauma are:

- Early separation from parents
- Neuroticism
- Pre-existing anxiety and depression, and
- A family history of anxiety

What is the association between PTSD and alcohol use?

The rate of alcohol abuse increases in relation to a current PTSD in males but not in females (Kozariæ-Kozæiæ, 2000). The co-morbidity of alcohol and PTSD found in females is more often influenced by alcohol problems existing prior to the trauma event, whereas in males it is not influenced by pre-trauma variables.

Females,PTSD, and Substance Abuse

From a review of the literature conducted by Najavitz,1997, female substance abusers show higher rates (30-59%), of PTSD associated to histories of repetitive childhood physical or sexual abuse. Male substance abusers have two to three times lower rates of PTSD. When in evidence, their PTSD generally stems from histories of crime or combat trauma.

In research conducted by Spak, et.al., 1997, sexual abuse in childhood is found to be the strongest predictor of later alcohol and drug abuse. Females with PTSD in treat-

ment for substance abuse are more likely to have been victims of sexual and/or physical abuse, particularly child abuse (Brady, et al., 1994). They had higher scores on a measure of substance abuse severity and were more likely to have co-morbid affective disorders and less likely to comply with treatment.

Thompson and Kingree (1998), report that in a sample of low-income pregnant females enrolled in substance abuse treatment, 72% experienced sexual assault, 67% experienced physical assault, 68% experienced indirect violent trauma, and 62% displayed symptoms consistent with PTSD. Obviously, when times are stressful, females may carry more inherent risks for relapse.

Substance Abuse, PTSD, & Adolescents

Adolescent suicide victims with a history of PTSD were more likely than those without PTSD to have had earlier exposure to suicide or suicidal behavior and to come from households with a history of disruptions in key relationships. They are also more likely to have past alcohol and other drug use, prior suicide attempts, family history of panic disorder and a history of loss (Brent, et al. 1995).

The lifetime prevalence of PTSD among a sample of chemically dependent adolescents was five times that reported for a community sample of adolescents (Deykin and Buka, 1997).

Adolescents who have been physically or sexually assaulted who have witnessed violence, or who have family members with alcohol or drug problems were reported to have an increased risk for current substance abuse or dependency (Kilpatrick et al. 2000). Clearly, those with PTSD symptoms have an increased risk for marijuana and hard drug abuse/ dependency (Kilpatrick, et al.)

PTSD and Major Depression are associated with significant adverse effects on the psychological, physical and social functioning of adolescents. (Clark and Kirisci, 1996).

Minority Populations PTSD and Substance Abuse

African Americans, but not Hispanics or Native Americans, have approximately one-third the risk for substance abuse or dependency compared with Caucasians. Wisman (1993), found that crack dealing in two African-American inner city communities was often found to have social dynamics and consequences separate from those of crack use. PTSD was associated more with the violence associated with crack dealing, and the shaping of adolescent identify by the associated cultures of violence.

Substance Abuse, PTSD and Treatment

The major challenge in treating the co-morbidity of PTSD and substance abuse is the development of individual treatment plans that adequately address the array of problems that are present. Co-morbidity of any type has detrimental effects on clinical presentation, treatment course, and outcome (Back, et al., 2001).

The Harvard Mental Health Letter (January 2002), reports that in a 1998 review of 41 controlled studies of PTSD treatment, psychotherapy was more effective than prescription drugs alone. Behavioral Cognitive Therapy was particularly helpful with treatment results that persisted. It was recommended that psychotherapy should be continued at least once a week for three months after improvement of symptoms with booster sessions at long intervals after that.

Simon (1999) identified 11 factors influencing treatment prognoses of individuals co-morbid for PTSD and alcohol or substance abuse. These were:

1. PTSD stressors
2. PTSD symptoms
3. Current and lifetime co-morbidity
4. Childhood separation
5. Childhood abuse
6. Demographics
7. Life stressors
8. Family history of PTSD
9. Supports
10. Treatment; and
11. Functional impairment.

Brown (2000) reports that the baseline severity of PTSD, but not the baseline severity measure of substance abuse, was a predictor of alcohol/drug relapse. Brown noted the importance of routine trauma screening and the need for more effective treatment for substance abusers with concomitant PTSD.

Females have more psychological risk factors associated with relapse but are more likely than males to engage in the treatment process. Engagement in treatment, notably the frequency of participation in group counseling, appears to mitigate higher risk of relapse for females (Gil-Rivas, et al., 1996).

Back et al., (2001) described a manual designed specifically for individuals with PTSD and cocaine dependence. Coping skills training, cognitive restructuring techniques and relapse prevention techniques targeting the reduction of cocaine use and in vivo imaginal exposure therapy techniques were incorporated to reduce PTSD symptoms. Primary treatment goals include psychoeducation specific to the interrelationship between PTSD and drug use working toward the reduction of

PTSD symptomatology. Secondary treatment goals should target the reduction of high risk behaviors, an increase in all functional areas, and anger and negative affect management.

It is important to treat both addiction and trauma at the outset of substance abuse treatment. Without the diagnoses and treatment of the trauma, female substance abusers in particular are vulnerable to relapse and re-victimization (Bollerud, 1990).

Harris (1996) introduced a three pronged, trauma based treatment approach for dually diagnosed females who had been sexually abused. Treatment included:

- Supportive group therapy
- Cognitive reframing
- Social skills training
- Education

Training focused on:

- Sexual and physical abuse
- Female identity
- Sexuality
- Safety
- Self-soothing
- Parenting

Patients who are simultaneously in treatment for PTSD and substance abuse appeared to have poorer treatment compliance than patients who are in substance abuse treatment alone. Triffleman et al., (1999) reported on a treatment model involving a five month treatment course with individual counseling twice a week. Cognitive-behavioral treatment was employed as well as relapse prevention and coping skills training for issues related to substance abuse; stress inoculation training and in vivo exposure were used to address PTSD symptoms.

Heibert-Murphy and Wohytkiw, (2000) offer a feminist-oriented, clinical approach involving the following stages; engaging and assessing, creating safety, intense debriefing, integration, and moving on.

Attending To the Needs of the Care Giver

Najavits (2000) introduced a training program for clinicians. Seeking Safety Psychotherapy for Patients with PTSD and Substance Abuse, is a manual based, 25 session, cognitive-behavioral approach. Techniques included:

- Observation of the clinician in action
- Watching videotapes of good vs. poor sessions
- Rehearsal of tough case scenarios
- Peer supervision
- The identification of key themes
- Thinking aloud modeling

Supervisory principles highlighted include the use of coping skills used by the trainee in their own lives, eliciting patient feedback, and encouraging the trainees to focus on behavior more than words.

In summary, caregivers of those with PTSD are themselves at risk. Self-care and supervisory vigilance are mandatory when our best workers are on the front line. Breaks, home time, de-briefings, etc. all help.

Prevention

To help reduce the impact of trauma, many communities have formed Interdisciplinary Critical Incident Stress Management Teams. These teams are organized to provide a rapid response to caregivers following a traumatic event. Members of the team include medical personnel, social workers, emergency personnel, mental health specialists, pastoral care personnel and appropriate administrators. To gain more information about these teams, contact the International Critical Incident Stress Foundation at www.icif.org.

A review of the literature has found no evidence that single session debriefing is effective in reducing PTSD for caregivers to trauma victim or the victims of trauma. Some studies actually suggest that this technique can increase the risk of PTSD (Wessely, S. and J. Bison, [2001]),

Nothing replaces personal supervision, cathartic release of emotions and positive life balance… it's the requirement!

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