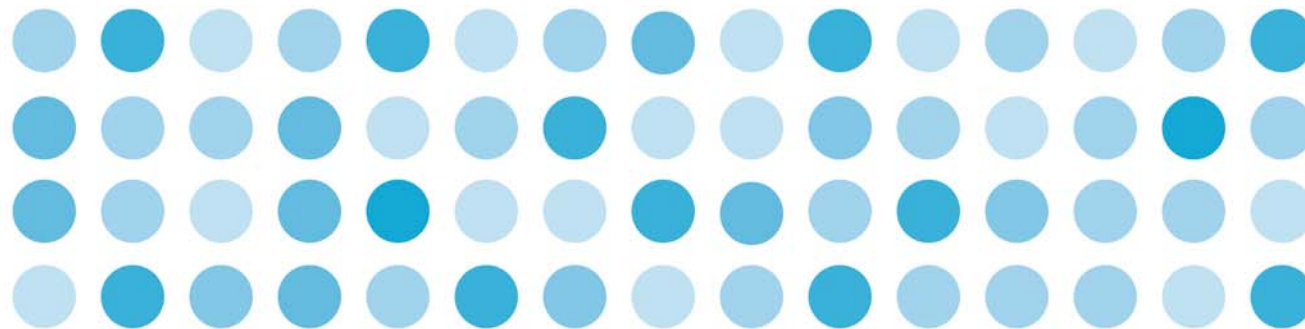


25-26 October 2010
Melbourne Cricket Ground



Anex 2010

AUSTRALIAN DRUGS CONFERENCE

Public Health and Harm Reduction

Richard Gray



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NATIONAL DRUGS CONFERENCE Melbourne 2010

Trauma-related comorbidity

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Acknowledgements

Enhanced Care for clients on opioid substitution treatment:

The effectiveness of case management, motivational and skills-based interventions on retention, drug use and psychosocial functioning.

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Enhanced Care Study

Participant profile

N=107

Age	M= 35 yrs, SD = 9.3
Sex	52% male, 48% female
ATSI Origin	20%
Children	28% no children 20% 1 child 21% 2 children 31% (3 or more children)
Educational Level	55% finished before yr 10 30% finished at yr 10

Participant profile (continued)

Source of Income	86% unemployment benefits/ pension 10% PT employment
Living arrangements	38% live with parents/relatives/friends 22% live alone 14% live with partner & children 14% live as sole parent 12% live with partner
Primary Drug of Concern	78% heroin
Previous Pharmacotherapy treatment	65%
Length of treatment	6 years (mean), n=69

Participant profile (continued)

<i>Drug</i>	<i>Self-report % clients using (n=107)</i>	<i>Mean weekly Consumption</i>	<i>Urinalysis % positive result (n=49)</i>
Tobacco	92.5	105.6 cigarettes	-
Cannabis	47.2	40.0 joints/cones	51.1
Alcohol	24.5	13.8 standard drinks	-
Tranquillisers	23.8	20.7 pills/ hits	18.4
Amphetamines	9.3	3.4 pills/hits/snorts	16.3
Heroin	7.5	12.1 hits/pills/smokes	10.2
Other opioid	6.5	4.0 hits/pills/smokes	

Participant profile (continued)

SF-12

The mean physical summary score was in the mild range of disability

The mean mental summary score was in the moderate range of disability

Brief Symptom Inventory

50% or more of clients showed clinically significant scores for 8 of the 9 symptom dimensions

69% of clients showed clinically significant scores per the Global Severity Index

Trauma Exposure
Brief Index of Interpersonal Trauma

Early Trauma/abuse <17ys	72%
Later Trauma/abuse >17yrs	65%

Brief Index of Interpersonal Trauma (Childhood <17 yrs)

	Male	Female	Pearson's Chi square
Domestic violence	54.5%	68.6%	Not significant
Sexual abuse	23.6%	52.9%	p=.001
Physical abuse	50.9%	58.8%	Not significant

Brief Index of Interpersonal Trauma (Adult >17yrs)

	Male	Female	Pearson's Chi square
Domestic violence	37.5%	76.5%	p<.0001
Sexual abuse	1.8%	27.5%	p<.0001
Physical abuse	30.4%	72.5%	p<.0001

Brief Index of Interpersonal Trauma

Emotional Connectedness

	Male	Female
Father (before age 8)	2.6	2.9
Mother (before age 8)	3.5	3.4
Father (8-16 yrs)	2.4	2.6
Mother (8-16 yrs)	3.4	3.1

No significant difference between males and females.

Significant difference between father and mother levels of emotional support at both ages, $p < .0001$

Brief Index of Interpersonal Trauma

Emotional Connectedness

Participants who reported trauma exposure during childhood also reported that they received less emotional support during both early and late childhood

($r = -.37, p < .001$ and $r = -.41, p < .001$ respectively)

General Findings

- 1) both males and females within this study represent a highly traumatised clinical population
- 2) this clinical population demonstrated extensive comorbid mental health conditions & related functional impairments
- 3) average length of treatment was 6 years
- 4) socially disadvantaged group
- 5) 20% of participants were of ATSI origin
- 6) whilst 72% of participants had children, only 12% lived with a partner and children
- 7) extensive, chronic cannabis use

Key findings in regards to trauma exposure

- 1) Participants who reported trauma exposure during childhood also reported that they received less emotional support during both early and late childhood, in comparison to participants who reported no childhood trauma
- 2) Male and female participants reported similar levels of physical abuse and emotional abuse during childhood
- 3) Male and female participants reported similar levels of emotional support during childhood
- 4) Both male and female participants reported experiencing less emotional support from their fathers than their mothers during childhood
- 5) Female participants experienced more trauma on all measures during adult years

Key findings in regards to sexual assault

- 1) Female participants reported more sexual abuse, than their males cohorts, during both childhood and during adult years
- 2) Adult sexual abuse was significantly associated with elevated scores on BSI measures of;
 - paranoid ideation $t(103)=2.43, p.02$
 - psychoticism $t(103)=2.66, p.01$
 - positive symptom total $t(103)=2.43, p.02$
- 3) In a clinical population where somatisation scores were already high, child sexual assault demonstrated a mild additional effect
 $t(101)=1.85, p.07$

Links between Trauma Exposure, Post Traumatic Stress Disorder (PTSD)& Borderline Personality Disorder (BPD)

Comorbid Substance Use Disorder (SUDs) & PTSD Treatment
Study (Mills & colleagues, 2010)

Age of first Trauma Exposure

- 25% before 5 yrs old
- 50% before 8 yrs old
- 75% before 15 yrs old

73% of study sample screened positive for BPD

Australian Treatment Outcome Study (ATOS)

N=495

Major Depression (26% at initial assessment to 11% at follow-up)

Post Traumatic Stress Disorder (PTSD) 42%

Borderline Personality Disorder (BPD) 45%

ATOS – Clinical Outcomes

Post Traumatic Stress Disorder

Persons with **PTSD** had significantly poorer outcomes in terms of

- Occupational functioning
- Overdose
- Physical Health
- Mental Health

ATOS – Clinical Outcomes Borderline Personality Disorder

- Higher levels of needle sharing (odds ratio (OR) 3.21)
- More injection-related health problems (OR 1.90)
- Higher likelihood of heroin overdose (OR 1.92)
- Poorer global psychological health (OR 2.43)
- Higher levels of current major depression (OR 3.19)
- Higher likelihood of attempted suicide (OR 3.89)

Conceptual / Diagnostic Considerations

PTSD and BPD can be conceptualised as lying on a
continuum of trauma-related disorders
(Nijenhuis, 2003; C. Ross, 1997, 2000)

Simple PTSD -> Complex PTSD -> BPD -> Dissociative Disorders (DD)

depression and anxiety are pervasive phenomena across this spectrum.
(Sar & Ross, 2006)

Post Traumatic Stress Disorder

Person experienced, witnessed or was confronted with an unusually traumatic event that:

- a) Involved actual or threatened death or serious physical injury
- b) They felt intense fear, horror, or helplessness

Symptom Criteria:

1. intrusive re-experiencing of traumatic events
2. numbing and/or avoidance
3. hyperarousal/anxiety

Complex PTSD & Disorders of Extreme Stress not otherwise specified (DESNOS)

Include the following symptom clusters, in addition to those described in simple PTSD:

- alterations in the regulation of affective impulses
- alterations in attention and consciousness
- alterations in self perception
- alterations in perception of the perpetrator
- alterations in relationship to others
- somatisation and/or medical problems
- alterations in systems of meaning.

Borderline Personality Disorder

- efforts to prevent abandonment
- unstable interpersonal relationships
- identity disturbance
- impulsiveness
- self-mutilation and/or suicidal thoughts/behaviours
- affective instability
- chronic feelings of emptiness
- anger, and difficulty controlling anger
- transient stress related paranoid ideas and/or severe dissociative symptoms

History of the study of Trauma-related Conditions

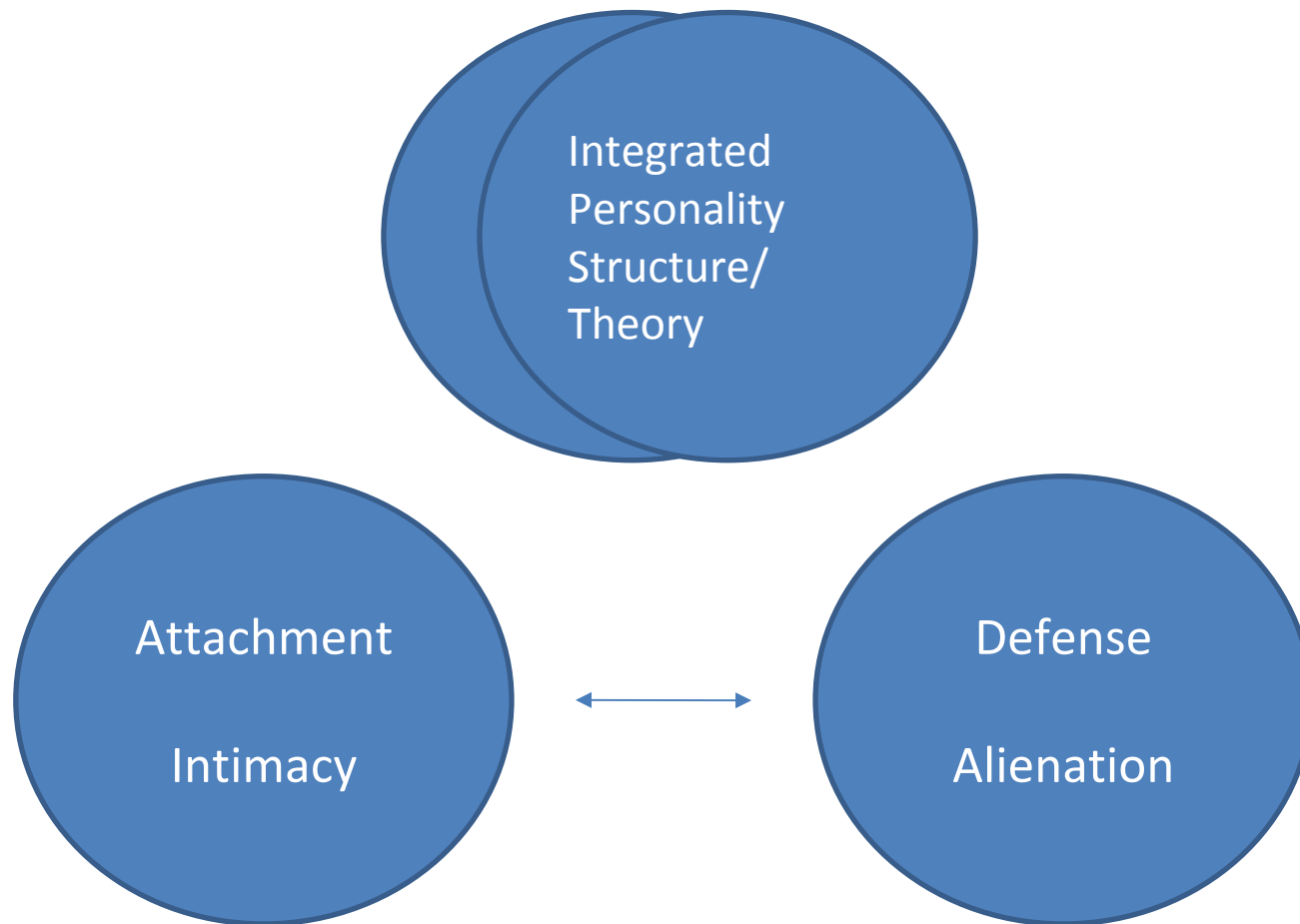
Hysteria - Hippocrates
Kramer & Sprenger
Mitchell, Hughlings Jackson, Senguin
Charcot, Bruer, Freud, Janet, James, Erickson

War Trauma - Mitchell, Kardiner
Vietnam Veterans Association
Medecins Sans Frontiers, UNICEF & UNIFEM

Feminist Movement - Russell, Herman

Australian - Summers
Perkins, Walker

Dialectics and Double Binds



Guidelines for Judging whether an association is causal

1. Temporal Relationship
2. Strength of Association
3. Dose-Response Relationship
4. Replication of the Findings
5. Biologic Plausibility
6. Consideration of Alternate Explanations
7. Cessation of Exposure
8. Consistency of Other Knowledge
9. Specificity of the Association

Concluding Remarks & Key Issues

- 1) trauma-related conditions are associated with AOD issues within the general population
- 2) trauma-related comorbidity is endemic within AOD clinical populations
- 3) lack of consensus regarding the causal links between trauma exposure and comorbidity
- 4) clinical populations with trauma-related comorbidity, in the main, represent previously undiagnosed cases of Developmental Trauma Disorder (proposed DSM-V diagnostic category)
- 5) females continue to experience significantly higher rates of trauma, particularly sexual assault

Concluding Remarks & Key Issues (cont.)

- 6) important for AOD workers to develop conceptual understanding of trauma-related mental health conditions
- 7) trauma-related organic and psycho-somatic conditions also contribute significantly to individual/family suffering and public health costs and further add to the burden associated with AOD abuse
- 8) chronic cannabis use amongst AOD clinical populations can contribute to *amotivational ways of being* and exacerbate mental and physical health problems

Concluding Remarks & Key Issues (cont.)

- 9) people of ATSI origin continue to be over-represented in AOD populations and experience severe, chronic trauma-related comorbidity
- 10) refugees will continue to seek safety – civilians accounted for 15% of war casualties in the early 20th century, in the early 21st century they now account for 85%
- 11) challenges of interrupting the intergenerational transmission of abuse and neglect within AOD populations
- 12) satisfactorily negotiating the various “Double-binds”

Concluding Remarks & Key Issues (cont.)

Addiction models need to include the notion of the *Social Brain*



Trauma, attachment and dissociation



Integrated biopsychosocial treatment interventions