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# 'Between pain and nothing, I choose nothing': trauma, post-traumatic stress disorder and substance use

The title quotation is of unknown origin, but it is one to which many substance users with a history of trauma and post-traumatic stress disorder (PTSD) ascribe. They would rather feel nothing at all than feel the pain of what they have experienced.

Exposure to traumatic events and PTSD is not at all uncommon among people with substance use disorders (SUD). There is a growing epidemiological and clinical literature documenting the high prevalence of trauma and PTSD among people with SUD, particularly those who use opioids, sedatives or amphetamines [1,2]. For example, among Australians with opioid, sedative or amphetamine use disorders, trauma exposure is almost universal (88–93%), and between one-quarter and one-third have current PTSD. In comparison, the population prevalence of trauma exposure and current PTSD is 57% and 1.3%, respectively [2]. For a large proportion, the onset of PTSD precedes the development of the SUD [3]; however, intoxication and the substance-abusing lifestyle (particularly that which is associated with the use of illicit substances) also places individuals at greater risk of trauma exposure, particularly interpersonal violence [4].

It is easy to understand why a person would turn to substance use, or increase their use, following exposure to traumatic events. Research has demonstrated, however, that exposure to trauma itself is not sufficient to increase one's risk of developing a SUD; rather, it is the development of PTSD following the event that confers increased risk [3]. According to DSM-IV, PTSD is an anxiety disorder characterized by the development of three symptom clusters following extreme trauma: (i) persistent re-experiencing of the traumatic event in the form of intrusive thoughts, flashbacks, nightmares and psychological reactivity to reminders of the trauma; (ii) persistent avoidance of stimuli associated with the trauma (i.e. efforts to avoid reminders associated with the trauma and to suppress thoughts and feelings about it) and numbing of general responsiveness (inability to feel close to others, to experience positive emotions or enjoy pleasurable activities); and (iii) persistent symptoms of increased arousal such as hypervigilance, exaggerated startle response, difficulties concentrating, sleep disturbance and irritability.

These symptoms can be extremely distressing and often cause impairment in social, occupational and other areas of functioning. It is these symptoms that many people with SUD appear to be self-medicating. This is not to say that PTSD has caused their SUD; there are many pathways that might lead to the co-occurrence of these (and other) disorders [3]. Rather, regardless of the order in which trauma exposure, PTSD, substance use or SUD occurred, many people with SUD and PTSD attribute their use, at least in part, to their need to suppress their PTSD symptoms.

After listening to accounts of how these symptoms affect peoples' lives, it is not difficult to understand the desire to try to contain them—and substance use is a very effective way of doing so. Unfortunately, this is only a short-term solution and may lead to other negative consequences. In the long term, substance use only serves to perpetuate these symptoms. Repeated avoidance of trauma-related symptoms is one factor that has been associated with their persistence [5], with symptoms returning as if to signify that there is unfinished business. People with SUD often report that their PTSD symptoms return or increase when they cut down or stop using, making it difficult for them to maintain abstinence or reduced use. Thus, a cyclical relationship develops between the two disorders.

What can clinicians do to break this cycle? How is PTSD best treated among people with SUD? Although no research has been conducted to date comparing integrated versus sequential or parallel treatment paradigms for this comorbidity, there is consensus in the literature that both disorders should be treated in an integrated fashion [6]. That is, both disorders should be treated at the same time by the same clinician. Patients also indicate that this is how they would prefer to receive treatment [6].

A number of integrated treatment protocols have been developed to treat this comorbidity and a growing number of studies are being undertaken to evaluate their effectiveness [7–16]. Existing treatment models may be divided into two types: past-focused and present-focused therapies [17]. Past-focused therapies involve exposure techniques which expose the person to the traumatic memory. Exposure-based treatments have long been considered the 'gold standard' in treating PTSD [18]; however, anecdotal evidence suggests that clinicians have been reluctant to use these techniques with SUD patients due to concerns that the distress evoked may be too overwhelming, and could lead to relapse or increased substance use. Two uncontrolled pilot studies provide support for the safety and efficacy of these techniques in patients with SUD [8,11]; however, their use in this population requires further

investigation. A number of randomized controlled trials are currently under way.

Present-focused therapies focus upon providing the patient with coping skills to manage their trauma symptoms in the present without revisiting the traumatic memory. A number of these therapies were trialled recently in the pioneering 'Women, Co-Occurring Disorders and Violence Study'. This large-scale multi-site study demonstrated that participation in integrated, trauma-informed services results in improved treatment retention, and significantly greater improvements in trauma and other mental health symptoms relative to treatment as usual for substance use [15,19]. This and other studies of present-focused therapies have demonstrated promising support for these models in improving outcomes across a number of domains [7,16].

Which treatment approach should be used? There is little research to guide this decision. The choice of treatment approach, if any, is up to the clinician and the patient. It is important to realize that some patients may not want, or be ready, to address their trauma-related issues; the fact that a person has presented to SUD treatment does not necessarily mean that they want to delve into their past traumas. Those who do wish to receive treatment may have a preference for either past- or present-focused therapy. Choice of treatment will also depend upon the clinician's experience and expertise. Not all SUD clinicians will be able to provide PTSD treatment. It is essential that clinicians who decide to engage in trauma therapy undergo appropriate training and receive adequate support and supervision. For those clinicians who decide not to provide PTSD treatment, it is important to recognize that SUD patients with PTSD can benefit from receiving traditional substance use treatments [20,21]. It appears, however, that to effect long-term changes in relation to substance use the underlying pain needs to be addressed.

## Declaration of interest

None.

KATHERINE L. MILLS
*National Drug and Alcohol Research Centre, University of New South Wales, NSW, 2052, Australia. E-mail: k.mills@unsw.edu.au*

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