6 Marshall M, Lockwood A, Bradley C, Adams C, Joy C, Fenton M. Unpublished rating scales: a major source of bias in randomised controlled trials of treatments for schizo-phrenia. *Br J Psychiatry* 2000; **176**: 249–52.

7 WHO Scientific Group on Treatment of Psychiatric Disorders. *Evaluation of Methods for the Treatment of Mental Disorders.* World Health Organization, 1991.

8 Lieberman JA, Stroup TS, McEvoy JP, Swartz MS, Rosenheck RA, Perkins DO, et al. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *N Engl J Med* 2005; **353**: 1209–23.

9 Cotton SM, Yuen HP, Berger G, McGorry P. Last observation carried forward in psychiatric research – a flawed gold standard. *Aust N Z J Psychiatry* 2005; **39**: 622.

10 Bain MRS, Chalmers JWT, Brewster DH. Routinely collected data in national and regional databases – an underused resource. *J Public Health Med* 1997; **19**: 413–8.

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SHAHEEN SHORA, ELIZABETH STONE AND KERON FLETCHER

Substance use disorders and psychological trauma

AIMS AND METHOD

The Impact of Events Scale was administered to 104 in-patients detoxing from alcohol or opiates to determine the prevalence of psychological trauma, the severity of its symptoms and the types of trauma responsible for symptoms.

RESULTS

Out of the 104 in-patients undergoing detoxification, 75 had symptoms of psychological trauma; in 60 patients the symptoms were in the treatable range. Patients with alcohol-dependence were more severely affected. 'Life events' traumatised a higher proportion of individuals than 'traumatic events'.

CLINICAL IMPLICATIONS

Psychological trauma requiring treatment is commonly found in substance misusers. This is rarely addressed despite the cormorbid disorder running a complicated clinical course. There are conflicting opinions about best practice, but consideration should be given to providing patients with accessible treatments for psychological trauma.

There are strong associations between substance misuse and psychological trauma. According to one US study, 3% of substance misusers in the general population have post-traumatic stress disorder (PTSD).[1] Rates of PTSD in female substance misusers on in-patient units rise to 42.5%[2] and to 62% for pregnant women treated in a residential setting.[3] In the UK, rates of PTSD on in-patient substance misuse units have been reported at 38.5% for current PTSD and at 51.9% for lifetime PTSD.[4] Surveys of adolescent substance misusers report PTSD rates of up to 19.2%.[5]

In civilian populations without PTSD, rates of lifetime substance misuse range from 8.1 to 24.7%, but in those with PTSD the levels rise to 21.6–43.0%.[6–8] Up to 75% of US and UK war veterans with PTSD meet the criteria for alcohol misuse or dependence.[9,10]

Individuals with comorbid substance misuse and PTSD are more likely to have other psychiatric diagnoses, higher rates of psychosocial and physical problems, higher rates of in-patient admissions for substance misuse and higher rates of relapse compared with substance misusers without PTSD.[8,11]

Within the general population, estimates of childhood sexual abuse in women are around 21–22% and in men 7–15%.[12,13] However, childhood sexual abuse levels among substance misusers on in-patient detoxification units range from 49 to 67% for women and 12–33% for men.[14–16]

The association between substance misuse and psychological trauma is therefore important, not only because of the frequency of comorbidity and the additional complexity of the presentation, but also because of the more complicated clinical course and poorer prognosis.

This paper presents the results of a survey of 104 individuals with alcohol or opiate dependence who were undergoing a detoxification at New House Drug and Alcohol Unit, Shrewsbury, Shropshire. The survey sought to identify the number of individuals who were currently affected by symptoms of psychological trauma, to assess the severity of any psychological trauma using the Impact of Events Scale (IES),[17,18] and to identify and describe the sorts of events that patients considered to be responsible for the development of their psychological trauma symptoms. Implications for the management of these individuals are discussed in the light of research findings and the National Institute for Health and Clinical Excellence (NICE) guidelines for the management of PTSD.[19]

Method

All individuals who participated in this survey had given informed consent. A total of 104 in-patients with alcohol or opiate dependence undergoing detoxification were assessed for current symptoms of psychological trauma using the Impact of Events Scale (IES). This instrument was administered when patients were no longer experiencing any acute symptoms of alcohol or opiate

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detoxification. The IES grades the severity of 15 characteristic symptoms of psychological trauma that have been experienced in the 7 days before testing. Eight items of avoidance behaviour and seven items related to intrusive memories are measured. The maximum score is 75. Scores over 25 are considered to indicate a level of disorder that requires treatment. The severity of symptoms were rated as subclinical (scores between 0 and 8), mild (9–25), moderate (26–43) and severe (scores over 43) in accordance with the guidelines of Corneil *et al*[20] (E. Hutchings, personal communication, 2004). The IES also records the date and nature of the event considered responsible for the symptoms of psychological trauma.

We used the χ^2-test for statistical analysis of proportions and the *t*-test for differences between means.

Results

The prevalence and severity of symptoms of psychological trauma according to type of dependence and gender are summarised in Table 1.

Overall, 75/104 patients had symptoms of psychological trauma: 60 patients had symptoms in the treatable range (IES > 25) and 25 scored in the severe range (IES > 43).

The number of traumatised patients with alcohol dependence (57/73) was significantly higher than the proportion of traumatised patients with opiate dependence (14/26; $\chi^2 = 5.552$, $P = 0.018$). Similarly, the mean IES score of patients with alcohol dependence was significantly higher than that of patients with opiate dependence ($t = 2.367$, $P = 0.019$). There were too few patients with dual dependence to draw any conclusions.

There were no significant differences between the IES scores of males and females. However, only 15/74 (20%) male patients scored in the severe range on the IES compared with 10/30 (33%) females, suggesting that there is a non-significant trend for females to experience severe symptoms of psychological trauma compared with males ($\chi^2 = 1.995$, $P = 0.16$).

Data showing the types of events considered responsible for symptoms of psychological trauma in 75 affected patients are summarised in Table 2.

'Life events' were responsible for symptoms in 56% of individuals. The mean IES score for life events was very close to that for 'traumatic events' (36.8 and 37.9 respectively).

Traumatic events occurred in 44% of the affected group. A significantly greater proportion of females in this group experienced severe symptoms (IES > 43; $n = 7/22$ females, $n = 5/53$ males; $\chi^2 = 5.796$, $P = 0.02$) and were significantly more likely to report childhood abuse ($n = 10/22$ females, $n = 9/53$ males; $\chi^2 = 6.663$, $P = 0.01$).

Discussion

The prevalence of symptoms of psychological trauma in patients on a detoxification unit was surprisingly high. The results of this survey suggest that over half of the

Table 1. Mean IES scores and prevalence data by severity[a]

IES trauma score	Alcohol dependence $n = 73$	Opiate dependence $n = 26$	Dual dependence $n = 5$	Gender	
				Male $n = 74$	Female $n = 30$
Mean IES scores	29.7	19.0	29.4	25.6	30.4
IES scores 0–8 (subclinical)	16	12	1	21	8
IES scores 9–25 (mild)	11	3	1	12	3
IES scores 26–43 (moderate)	26	8	1	26	9
IES scores 44–75 (severe)	20	3	2	15	10

IES, Impact of Events Scale

a. n=104 in-patients (study participants).

Table 2. Life events and traumatic events that patients associated with psychological trauma

Event	Symptomatic patients, *n*
Life event	
Death (e.g. loss of parents/siblings/children)	23
Divorce or separation (e.g. voluntary or enforced separation from wife/husband/children)	15
Adult abuse (e.g. bullying at work, bullying within family, emotional abuse by partner, domestic violence)	4
Traumatic event	
Child abuse (e.g. childhood abuse (physical/sexual/emotional) perpetrated by parent or other family member)	19
Violent assault (e.g. held hostage, road traffic accident, industrial accident, rape, surgical complications)	9
Saw trauma (e.g. witnessed man shot in head, found hanging body, army service in Korea, saw boyfriend murdered, saw suicide of father)	5

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patients interviewed (58%) had symptoms in the range requiring treatment and almost a quarter (24%) had IES scores that were severe. It is not possible to make a diagnosis of PTSD from an IES score. However, these findings support the US and UK data.[2,4]

Patients with alcohol dependence were significantly more likely than patients with opiate dependence to report symptoms of psychological trauma and their greater severity. This may be due to the fact that the in-patient unit only admits people with complex, severe alcohol dependence, whereas, in contrast, access for opiate users is enhanced in order to meet current treatment targets. Life events were associated with symptoms in more individuals than traumatic events and, unexpectedly in our view, resulted in IES scores of equal severity. In this sample, the nature of the event itself appears to give little indication of the traumatising effect it may have. Life events would not be regarded within ICD–10 or DSM–IV as sufficiently extreme or catastrophic to induce PTSD. However, our observation is similar to that of Mol *et al*[21] and highlights a potential diagnostic anomaly in which all the symptoms of psychological trauma or PTSD may be present, but the nature of the traumatic incident eliminates a diagnosis. This inconsistency may be addressed in DSM–V.[22] A greater proportion of female patients reported IES scores in the severe range resulting from a traumatic event, and they were also more likely to report childhood abuse than male patients. These findings are consistent with those from previous studies.[4,11,16,23]

This survey demonstrates the value of routinely assessing substance misusers for symptoms of psychological trauma. Clinical and epidemiological studies confirm that comorbidity between PTSD and substance use disorders is common and that such patients tend to be more severely affected and more refractory to treatment than those having either disorder alone.[11,24]

Implications for clinical practice

The strong relationship between alcohol problems in particular and psychological trauma has implications for patient management. Existing research suggests that this client group may benefit from the following range of measures:[25]

- referral to specialist PTSD /mental health services
- simultaneous treatment of both conditions
- combined programme of pharmacotherapy and psychotherapy
- patient education
- learning coping and relapse preventions skills
- cognitive–behavioural therapy.

The NICE guidelines for the management of PTSD recommend tackling substance misuse difficulties before offering trauma-focused interventions (although this relates to simple cases of PTSD – the guidelines for the management of 'complex PTSD' have yet to be published).[19] However, this contrasts with advice from Lisa Najavits' 'Seeking Safety' programme and from Alcohol Concern, both of which recommend managing the two disorders simultaneously. Given the limited availability of specialist treatments for alcohol problems and PTSD even when they exist as separate disorders, in practice neither of these forms of advice is likely to be followed where there is comorbidity. Waiting times for trauma-focused interventions frequently prove too long for individuals with addictive disorders for whom the use of substances may be, in part, a way of coping with the symptoms of trauma. This failure needs to be addressed, especially for women, who are more likely to be severely traumatised, so that trauma services can be made accessible for those patients who are substantially vulnerable and severely affected.

Conclusions

The common and complex relationship between substance misuse and psychological trauma demonstrates the pressing need to screen for, and treat, both conditions. Despite the frequency with which individuals with comorbid disorder present for treatment, no systematic treatment approach of proven efficacy has been developed for this vulnerable patient group in the UK. Comorbid substance dependence and psychological trauma receives considerable attention in research, but very little emphasis in routine clinical practice.

Declaration of interest

None.

References

1 Cottler LB, Compton WM III, Mager D, Spitznagel EL, Janca A. Posttraumatic stress disorder among substance users from the general population. *Am J Psychiatry* 1992; **149**: 664–70.

2 Dansky BS, Saladin ME, Brady KT, Kilpatrick DG, Resnick HS. Prevalence of victimization and posttraumatic stress disorder among women with substance use disorders: comparison of telephone and in-person assessment samples. *Int J Addict* 1995; **30**: 1079–99.

3 Thompson MP, Kingree JB. The frequency and impact of violent trauma among pregnant substance abusers. *Addict Behav* 1998; **23**: 257–62.

4 Reynolds M, Mezey G, Chapman M, Wheeler M, Drummond C, Baldacchino A. Co-morbid post-traumatic stress disorder in a substance misusing clinical population. *Drug Alcohol Depend* 2005; **77**: 251–8.

5 Deykin EY, Buka SL. Prevalence and risk factors for posttraumatic stress disorder among chemically dependent adolescents. *Am J Psychiatry* 1997; **154**: 752–7.

6 Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB. Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry* 1995; **52**: 1048–60.

7 Breslau N, Davis GC, Andreski P, Peterson E. Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Arch Gen Psychiatry* 1991; **48**: 216–22.

8 Breslau N, Davis GC, Peterson EL, Schultz L. Psychiatric sequelae of posttraumatic stress disorder in women. *Arch Gen Psychiatry* 1997; **54**: 81–7.

9 Kulka RA, Schlenger WE, Fairbank JA, Hough RL, Jordan BK, Marmar CR, et al. *Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study*. Brunner/Mazel, 1990.

10 Fletcher KD. Combat stress (the Ex-Servicemen's Mental Welfare Society) and war veterans. In *War and Health: Lessons from the Gulf War*: 89–112. Wiley, 2007.

11 Najavits LM, Gastfriend DR, Barber JP, Reif S, Muenz LR, Blaine J, et al. Cocaine dependence with and without PTSD among subjects in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Am J Psychiatry* 1998; **155**: 214–9.

https://doi.org/10.1192/pb.bp.108.019554 Published online by Cambridge University Press

original papers

12 Kelly L, Regan L, Burton S. *An Exploratory Study of the Prevalence of Sexual Abuse in a Sample of 16–21 Year Olds.* University of North London, 1991.

13 López F, Carpintero E, Hernàndez A, Martín, MJ, Fuertes A. Prevalence and sequelae of childhood sexual abuse in Spain. *Child Abuse Negl* 1995; **19**: 1039–50.

14 Windle M, Windle R, Scheidt DM, Miller GB. Physical and sexual abuse and associated mental disorders among alcoholic in-patients. *Am J Psychiatry* 1995; **152**: 1322–8.

15 Moncrieff J, Drummond DC, Candy B, Checinski K, Farmer R. Sexual abuse in people with alcohol problems. A study of the prevalence of sexual abuse and its relationship to drinking behaviour. *Br J Psychiatry* 1996; **169**: 355–60.

16 Stone EA. *Childhood Sexual Abuse and Substance Misuse* (MSc dissertation). Imperial College London, 2005.

17 Horowitz M, Wilner N, Alvarez W. Impact of Events Scale. *Psychosom Med* 1979; **41**: 209–18.

18 Sundin EC, Horowitz ML. Horowitz's Impact of Event Scale evaluation of 20 years of use. *Psychosom Med* 2003; **65**: 870–6.

19 National Institute for Health and Clinical Excellence. *Management of Post-Traumatic Stress Disorder in Adults in Primary, Secondary and Community Care.* Clinical guideline 26. NICE, 2005.

20 Corniel W, Beaton R, Murphy S, Johnson C, Pike K. Exposure to traumatic incidents and prevalence of post-traumatic stress symptomatology in urban firefighters in two countries. *J Occup Health Psychol* 1999; **4**, 131–41.

21 Mol SSL, Arntz A, Metsemakers JFM, Dinant G-J, Vilters-van Montfort PAP, Knottnerus JA. Symptoms of post-traumatic stress disorder after non-traumatic events: evidence from an open population study. *Br J Psychiatry* 2005; **186**: 494–9.

22 Rosen GM, Spitzer RL, McHugh PR. Problems with the post-traumatic stress disorder diagnosis and its future in DSM–V. *Br J Psychiatry* 2008; **192**: 3–4.

23 Triffleman EG, Marmar CR, Delucchi KL, Ronfeldt H. Childhood trauma and PTSD in substance abuse in-patients. *J Nerv Ment Dis* 1995; **183**: 172–6.

24 Ouimette PC, Brown KT, Najavits LM. Course and treatment of patients with both substance use and posttraumatic stress disorders. *Addict Behav* 1998; **23**: 785–95.

25 Alcohol Concern. *Mental Health and Alcohol Misuse Project, Factsheet 6: Post-Traumatic Stress Disorder and Alcohol.* Alcohol Concern, 2004 (http://www.alcoholconcern.org.uk/files/20040709.145809.ptsd%20factsheet.pdf).

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Service user perspectives on the content of the undergraduate curriculum in psychiatry

AIMS AND METHOD

To explore user perspectives on the content and delivery of the undergraduate curriculum in psychiatry. The study design was qualitative and used focus groups. Four focus groups were run with a total of 28 participants.

RESULTS

The key finding was that participants were clearer about the attitudes they felt students should convey than they were about the skills and knowledge required.

CLINICAL IMPLICATIONS

Service user perspectives on the content of the undergraduate psychiatry curriculum need to be considered as curricula are developed.

The undergraduate curriculum is the first step to ensuring that graduating doctors are equipped with the essential skills and appropriate respectful attitudes that are associated with professionalism. Given the current statistic that one in four people has mental health problems at some time during their life,[1] doctors are likely to encounter mental health problems irrespective of which speciality they choose. Currently, only a small fraction of the undergraduate medicine course concentrates on the teaching of psychiatry (in some cases as little as 2 weeks).[2]

The Royal College of Psychiatrists[3] now requires user and carer involvement in postgraduate education and, in line with recommendations in *The National Service Framework for Mental Health*,[4] it is appropriate for service users to be involved in planning and providing the content of the undergraduate curriculum.

Service users and carers have had increasing input into health and social care education at a range of levels including medical training (e.g. Livingston & Cooper,[5] Tew *et al*[6]). Their role in delivering recommendations from *Tomorrow's Doctors*[7] that students need guidance on 'Communicating with people with mental illness including where patients have special difficulties in sharing how they feel and think with doctors' is evident. There is growing recognition of the spectrum of ways in which service users and carers can contribute to education.[8] Fadden *et al*[9] discuss four approaches to involvement in the training of psychiatrists: course planning, sharing experiences and perspectives, commenting on assignments and involvement in the selection of trainees. With a notable exception,[10] however, there has been very little systematic evaluation of the impact of involving people with direct experience of mental ill health as teachers and tutors. Recent studies have found that trainees are generally enthusiastic about patients contributing to their education and assessments although fears were expressed about the latter.[11,12] More has been written about service user involvement with psychiatric trainees than with medical students and their roles as teachers have been more widely explored than their potential contributions to curriculum development.