Treatment of Co-morbid PTSD and Substance Abuse

Brian L. Meyer, Ph.D.
PTSD-SUD Specialist
McGuire VA Medical Center
Richmond, VA
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Disclaimer

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The Co-Occurrence of PTSD and Substance Abuse

Co-occurring disorders are the rule rather than the exception.

(SAMHSA, 2002)
Co-occurrence of PTSD and Substance Abuse

National Comorbiditity Survey

Among those with PTSD:

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Abuse/Dependence</td>
<td>51.9%</td>
<td>27.9%</td>
</tr>
<tr>
<td>Drug Abuse/Dependence</td>
<td>34.5%</td>
<td>26.9%</td>
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</tbody>
</table>

Kessler et al., 1995
Co-occurrence of PTSD and Substance Abuse

- PTSD and substance abuse co-occur at a high rate
  - 20-40% of people with PTSD also have SUDs (SAMHSA, 2007)
  - 40-60% of people with SUDs have PTSD
- Among people with PTSD, 52% of men and 28% of women develop an Alcohol Use Disorder (Najavits, 2007)

Co-occurrence of PTSD and Substance Abuse

- Substance use disorders are 3-4 times more prevalent in people with PTSD than those without PTSD (Khantzian & Albanese, 2008)
- The presence of either disorder alone increases the risk for the development of the other
- PTSD increases the risk of alcohol relapse (Heffner et al., 2011) and substance relapse (Norman et al., 2007)
- The combination results in poorer treatment outcomes (Ouimette et al., 2003; Sonne et al., 2003)
Rates of SUDs in Vietnam Veterans with PTSD

Current  Lifetime

Alcohol Abuse/ Dependence  22%  75%

Drug Abuse/ Dependence  6%  23%

Kulka et al., NVVRS, 1988

Veterans in VHA Care with PTSD Diagnosis and SUD FY02-12

The number of users with SUD-PTSD more than tripled between 2002 and 2012
VHA, 2012
Pathways Between Trauma-related Disorders and Substance Use

Co-Occurring PTSD and SUDs Make Each Other Worse

- Substance abuse exacerbates PTSD symptoms, including sleep disturbance, nightmares, rage, depression, avoidance, numbing of feelings, social isolation, irritability, hypervigilance, paranoia, and suicidal ideation
- People who drink or use drugs are at risk for being retraumatized through accidents, injuries, and sexual trauma
The Truth about Self-Medication

• Only about 1/3 of people start abusing substances after their traumatic experience.
• About 1/3 experience trauma and start abusing substances simultaneously.
• About 1/3 abuse substances before they experience trauma.

Many Reasons Why People with PTSD Use Substances

• To numb their painful feelings (self-medication).
• To try to relax.
• To forget the past.
• To go to sleep.
• To prevent nightmares.
• To cope with physical pain.
• To stop dissociation and flashbacks.
• To feel some pleasure in life.
• To let out their anger.
Many Reasons Why People with PTSD Use Substances

- Physical pain.
- Peer pressure.
- To socialize with other people and feel accepted.
- Family members drank or used drugs when they were growing up.
- It was common in the military.
- Boredom.
- To get through the day.
- To show people how bad they feel.
- To commit “slow suicide.”

One More Reason: Confusion about Marijuana

- Four states have legalized marijuana (Washington, Colorado, Alaska, and Oregon)
- 23 states and Washington, DC, have legalized medical marijuana
- Many veterans claim marijuana helps their PTSD
- There are no studies yet about whether marijuana decreases PTSD symptoms
Marijuana and the Treatment of PTSD

- A recent observational study of more than 2,000 Veterans in PTSD treatment programs (Wilkinson et al., 2015) found:
  - Those who never used marijuana had significantly less severe PTSD symptoms than those who had used it or started using it after beginning PTSD treatment.
  - Those who used marijuana when they started treatment but stopped using it after the conclusion of treatment also had significantly less severe PTSD symptoms than those who continued to use it.
  - Those who started using marijuana after the start of treatment had the highest levels of violent behavior.

Wilkinson et al., 2015
PTSD/SUD Patients Have Significantly More Problems

- Other Axis I disorders
- Increased psychiatric symptoms
- Increased inpatient admissions
- Interpersonal problems
- Medical problems
- HIV risk
- Decreased motivation for treatment
- Decreased compliance with aftercare
- Maltreatment of children
- Custody battles
- Homelessness
The Rationale for Integrated Treatment

Why Should We Treat Co-Occurring Disorders Integratively?

- PTSD does not go away with abstinence; in fact, it may get worse, at least initially
- Improvement in PTSD symptoms does not bring about abstinence from substance use
- Even if substance abuse began as self-medication, it takes on a life of its own
- Separate treatment is usually uncoordinated and at worst countertherapeutic
- Integrated treatment leads to better outcomes
The Importance of Integrated Treatment for PTSD and SUDs

- Treating one disorder without treating the other is ineffective
- Sequential treatment (usually SUD first) is ineffective
- Fully integrated treatment is optimal
- Simultaneous treatment is next best

Complex Trauma and Substance Abuse

- People with complex trauma are likely to abuse substances
- Criterion A of DESNOS:
  Alterations in regulating affect arousal
  - Persistent dysphoria
  - Difficulty modulating anger
  - Self-injurious behavior
  - Suicidal preoccupation
  - Difficulty modulating sexual involvement
  - Addictive behavior
The Importance of Integrated Treatment for PTSD and SUDs

- Recent evidence on integrated and simultaneous treatment (Hien et al., 2010) suggests:
  - If PTSD symptoms decline, so do SUDs
  - If SUDs decline, PTSD symptoms do not
- Therefore, treating substance abuse without treating PTSD will fail
  - This includes ASAP programs

Barriers to Integrated Treatment

- Most insurance does not pay for substance abuse treatment
- Separate payment streams
- Separate treatment systems
- Professional training biases
- Lack of dually trained clinicians
Trauma-Informed ≠ Evidence-Based Treatment

- Trauma-informed treatment means that trauma is taken into account when treating substance abuse
  - *Beyond Trauma: A Healing Journey for Women* by Stephanie Covington
- Evidence-based means that research has shown treatment to be effective
  - *Seeking Safety* by Lisa Najavits
- Evidence-based is better

AA and NA in PTSD/SUD Treatment
PTSD and Abstinence

• For some people, PTSD symptoms improve in the early stages of abstinence
• For some people, PTSD symptoms worsen in the early stages of abstinence
  • This is often experienced as a flood of feelings
  • Like all floods, it passes

Traumatized People May Not Like AA/NA

• Reason #1: What is the first step?
• Reason #1: What is the first step?
  1. *We admitted we were powerless over alcohol - that our lives had become unmanageable.*

• Most traumatized people need control
  • Yes, it is a contradiction that they use substances that make them lose control
  • Admitting they are powerless violates their identity

• Reason #2: What is the third step?
  3. *Made a decision to turn our will and our lives over to the care of God as we understood Him.*

• Not all traumatized people believe in a higher power
  • They question why God let terrible things happen to them
  • Then they have three choices:
    1. God is good, so I am bad
    2. God is not good
    3. There is no God

• AA and NA depend on faith and trust, which many traumatized people lack
All Participants Do Not Respond in the Same Way

- More than 40% of participants drop out prematurely from self-help groups (Kelly & Moos, 2003)
- Some people are triggered by hearing stories of others drinking or using drugs
- Make sure your participants are not triggered to drink or use drugs by hearing stories of others drinking and using

Just to Be Clear

- AA and NA have helped millions of people
- This discussion is not meant to stop you from referring to AA and NA
- It is meant to make you think about which meetings are helpful to which people
  - AA and NA may not be helpful to all traumatized people
- The NADCP Adult Drug Court Best Practice Standards (Volume I, 2013) recommend using Peer Support Groups
  - The Standards do not recommend specific peer support groups
Alternatives to AA/NA: SMART Recovery

- Self Management and Recovery Training Groups
- Four Point Program
  1. Building and Maintaining Motivation
  2. Coping with Urges
  3. Managing Thoughts, Feelings and Behaviors
  4. Living a Balanced Life
- Allows the use of psychiatric medication
- Does not require belief in God
- Does not require belief that addiction is a disease

SMART Recovery

- A cognitive-behavioral approach to substance abuse
- Focuses on empowerment and self-reliance
- Uses empirically-supported treatment strategies
- Research shows it is effective (e.g., Hester et al., 2013)
- Provides tools and techniques
- Worksheets
- Web courses
- In person and online meetings
- Online resources
Integrated Treatment of PTSD and Substance Abuse

Phases of Integrated Treatment

Phase I: Safety and Stabilization
Phase II: Remembrance and Mourning
Phase III: Reconnection

After Herman, 1992
Stage I: Safety and Stabilization

- Alliance building
- Psychoeducation about multiple traumas
- Safety
- Stabilization
- Skills-building
  - Affective regulation
  - Cognitive
  - Interpersonal
  - Self-care

Stage I: Safety

- Safety plans
- Tension reduction activities (e.g., exercise)
- Harm reduction and elimination
  - Substance abuse
  - Self-harm and suicidal behaviors
  - Gambling
  - Driving
  - Fighting
  - Eating
  - Sex
  - Medication
  - Breaking laws
Stage I: Stabilization

- Elimination of drug and alcohol abuse
- Health
- Housing
  - In a safe neighborhood
- Income
  - Employment
  - Financial skills (budgeting, banking)
- Transportation
- Setting and keeping a schedule

Stage I: Skill-building

Affect Regulation Skills

- Anger Management
- Relaxation (breathing, progressive muscle relaxation, Drop 3, etc.)
- Emotional literacy
- Distraction from intense emotion
- Self-soothing strategies
- Behavioral activation
- Changing facial expressions
- Self-talk
- Opposite emotion
Stage I: Skill-building

Cognitive Regulation Skills
- Grounding
- Thought-stopping
- Attending to one thing in the present moment
- Re-thinking
- Noticing choices
- Seeing the whole picture
- Problem-solving
- Examining the evidence

Medication Treatment of Substance Use Disorders

- Alcohol:
  - Antabuse (Disulfiram)
  - Naltrexone
  - Acamprosate
- Opiates:
  - Methadone
  - Buprenorphine
Psychological Treatment of Substance Use Disorders

Evidence-Based Treatments:
• Motivational Interviewing
• Motivational Enhancement Therapy
• Cognitive-Behavioral Therapy (CBT)
• Contingency Management
• Twelve-step Facilitation Therapy
• Behavioral Couples Therapy

Medical Treatment of PTSD and SUDs

• Medication for symptom management and co-morbid disorders
  • Antidepressants
  • Mood stabilizers
  • Anticonvulsants
  • Sleep aids, including Prazosin for nightmares
  • *Atypical antipsychotics No longer*
  • Anxiolytics *Not benzodiazepines*
• Only SSRIs are approved for treating PTSD
• There is no medication that specifically “cures” PTSD
Psychological Treatment of PTSD and SUDs

Evidence-Based Psychotherapies for Integrated Phase I Treatment:

• Seeking Safety
• Dialectical Behavior Therapy (DBT)
• Therapies for specific problems
  • Imagery Rehearsal Therapy
  • Cognitive-Behavioral Therapy
  • EMDR resource building, safe place, etc.

Seeking Safety

• 25 lessons on topics that overlap between PTSD and Substance Abuse
  • Safety Skills
  • Grounding
  • Anger
  • Boundaries
  • Self-care
  • Honesty
  • Compassion
Seeking Safety

• Weekly 90 minute sessions
• Often taught in 12 sessions
• Can be provided individually or in groups
• Typical group size is 8 members
• Combined psychoeducational and psychodynamic treatment
• Can be provided by professionals or paraprofessionals

Seeking Safety Format

• Check-in (3-5 minutes per person)
  • Used to elicit information to be discussed during the course of the session
• Quotation
• Topic of the day (50 minutes)
• Check out with commitment
Seeking Safety Results

- 6 randomized controlled trials and 3 controlled studies
- Seeking Safety has shown positive results across all studies (Najavits & Hien, 2013)
- Populations include
  - Women outpatients, inpatients, Veterans, homeless women, rural women, and women in prison;
  - Men outpatients, inpatients, and Veterans;
  - Adolescent girls; and
  - Young African-American men.

Dialectical Behavior Therapy

- Combination of individual therapy and group DBT Skills Training
- Usually provided in teams with different therapists
- One therapist carries a beeper and takes emergency phone calls for coaching DBT skills
- DBT Skills Training group lasts one year, with each topic covered twice
DBT Skills Training

- Four topics with multiple lessons
  - Mindfulness
  - Interpersonal Effectiveness
  - Distress Tolerance
  - Affect Regulation
- New manual provides suggested menus of different specific skills and exercises with different populations

DBT Results

- 18 randomized controlled trials
- Results are all positive
- Populations include:
  - Women: with Borderline Personality Disorder (BPD) and suicidality, with BPD and substance dependence, with bulimia nervosa, with binge eating disorder, with opiate-addiction and BPD, domestic violence victims, with childhood sexual abuse, and with trichotillomania;
  - Adults: with BPD, with personality disorders, with Bipolar Disorder, prisoners with intellectual disabilities, and prisoners with impulsivity;
  - Male prisoners; and
  - Adolescents: suicidal, female offenders, with self-injurious behavior, with eating disorders.
Stage II: Remembrance and Mourning

- Exposure and desensitization
- Processing
- Grieving
- Constructing a narrative
- Integration of the trauma

Treatment of PTSD in Phase II

Evidence-Based Psychotherapies for Phase II Trauma Treatment:
- Cognitive Processing Therapy (CPT)
- Prolonged Exposure (PE)
- Eye Movement Desensitization and Reprocessing (EMDR)
  - EMDR has a specific protocol to deal with urges to use substances
Stage III: Reconnection

- Gradually decrease isolation
- Re-establishing estranged relationships
- Developing trusting relationships
- Developing intimacy
- Developing sexual intimacy
- Parenting
- Community-based activities
- Spirituality

Stage III: Reconnection

- Giving back to the community
- Making amends
- Acceptance
- Reclaiming
- Creativity
- Finding meaning
- Post-traumatic growth
Stage III: Reconnection

• There are no Evidence-Based Psychotherapies for Phase III trauma treatment
  • but couples and/or family therapy may be helpful
• Cognitive-Behavioral Conjoint Therapy for PTSD shows promise (Monson and Fredman, 2012)

Integrated Treatment for PTSD and Substance Abuse

Seeking Safety is the only empirically-supported integrated treatment for both PTSD and Substance Abuse
But it is only a Phase I treatment for Safety and Stabilization
Recent Research on Treatment for PTSD and SUDs

- Two recent studies of treatment of PTSD and SUDs using Prolonged Exposure and simultaneous SUD treatment show mixed results
  - Exposure therapy does not increase substance use
  - One study found that integrated exposure therapy plus SUD treatment improves trauma symptoms but not substance abuse, depression or anxiety compared to TAU (Mills et al., 2012)
  - The other found that Prolonged Exposure plus Naltrexone does not improve trauma symptoms more than treatment as usual (Foa et al., 2013)

Promising Treatments: Mindfulness Meditation

- Mindfulness Meditation
  - DBT
- Mindfulness-Based Stress Reduction
  - MBSR reduces PTSD symptoms in Veterans (Kearney et al., 2012; Kluepfel et al., 2013)
- Mindfulness-Based Relapse Prevention for substance abuse
- Acceptance and Commitment Therapy
Promising Treatments: STAIR Narrative Therapy

- Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy (Cloitre et al., 2006)
  - Uses coping skills from Stress Inoculation Training and Dialectical Behavior Therapy
  - 8-10 sessions of skills building and 8 sessions of narrative therapy
  - This is the only Phase I and Phase II treatment for trauma and complex trauma

Resources
PTSD and SUDs

- PTSD 101 course about treating PTSD and SUDs:
  www.ptsd.va.gov/professional/ptsd101/course-modules/SUD.asp
- Practice recommendations for treating co-occurring PTSD and SUDs:
- www.smartrecovery.org
- http://smartrecoverytraining.org/moodle/
- http://www.smartrecovery.org/community/#.Vims8GtRl2Y

SMART Recovery

- www.smartrecovery.org
- http://smartrecoverytraining.org/moodle/
- http://www.smartrecovery.org/community/#.Vims8GtRl2Y

SMART Recovery App
Seeking Safety

- *Seeking Safety* (1998), Lisa Najavits
- *8 Keys to Trauma and Addiction Recovery* (2015), Lisa Najavits
- [http://www.treatment-innovations.org/seeking-safety.html](http://www.treatment-innovations.org/seeking-safety.html)

Dialectical Behavior Therapy

- *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (1993), Marsha Linehan
- [http://www.behavioraltech.com](http://www.behavioraltech.com)
Prolonged Exposure

- *Reclaiming Your Life from a Traumatic Experience: A Prolonged Exposure Treatment Program Workbook* (2007), Barbara Rothbaum, Edna Foa, and Elizabeth Hembree

Cognitive Processing Therapy

EMDR

- *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy* (2013), Francine Shapiro
- [www.emdr.com](http://www.emdr.com)
- [www.emdria.org](http://www.emdria.org)
- [www.emdrhap.org](http://www.emdrhap.org)

Resources

- *Trauma and Substance Abuse (2nd ed.)* by Page Ouimette and Jennifer Read
- *Treating Survivors of Childhood Abuse: Psychotherapy for the Interrupted Life* by Marylene Cloitre, Lisa Cohen, and Karestan Koenen
Internet Resources

- PTSD 101 course about treating PTSD and SUDs: http://www.ptsd.va.gov/professional/ptsd101/course-modules/SUD.asp
- Practice recommendations for treating co-occurring PTSD and SUDs: http://www.ptsd.va.gov/professional/pages/handouts-pdf/SUD_PTSD_Practice_Recommnd.pdf

Contact:
Brian L. Meyer, Ph.D.
Brianlmeyerphd@gmail.com