

Conceptualizing PTSD and Addictions Treatment

NIDA Blending Conference:
 Evidence-Based Treatment and Prevention
 in Diverse Populations and Settings

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Recent Veterans

Population	Percent SUD	Source:
General Population	3-4.7% Alcohol Abuse	National Comorbidity Survey Replication 2005
	3.8% Current SUD	National Comorbidity Survey Replication 2005
Veterans	7.1% Current SUD	National Survey on Drug Use and Health 2004-2006
Returning Iraq Vets	12% Alcohol Misuse	Hoge et al., JAMA 2007

PTSD and SUDs in Iraq/Afghanistan Veterans

Rand Study – Dec 2008

- **Binge Alcohol:** 50% (2x community)
- **Tobacco Smoking:** 50% (2x community)
- **Opiate Abuse:** 09% (3x community)
- **Other Drugs:** Marijuana, Sedatives, etc.

Slide from: Kosten, Thomas, Treating PTSD and Addiction, 2009 Presentation

Why High Co-Occurrence?

- **Self-Medication Hypothesis:**
 - PTSD increases the positive reinforcement of substances.
 - Alcohol and drugs facilitate numbing, withdrawal, and isolation
 - Alcohol assists in falling asleep
 - Marijuana reduces aversive memories, reactivity,
- **Substance Use Disorder Vulnerability Hypothesis:**
 - SUD predisposes/mediates/facilitates the development of PTSD
 - SUD increases risk-taking and sensation-seeking behaviors
- **Common Genetic/Neurobiological Dysfunction:**
 - Increased arousal of CNS
 - Increased tendencies for avoidance
 - Tendency for fear-based reactivity

Clinical Symptom Overlap


<p>DRUG WITHDRAWAL SYMPTOMS</p> <ul style="list-style-type: none"> ■ Insomnia ■ Psychomotor agitation ■ Heightened Anxiety ■ Autonomic hyperactivity ■ Craving for alcohol or drugs ■ Tremor 	<p>PTSD HYPERAROUSAL SYMPTOMS</p> <ul style="list-style-type: none"> ■ Difficulty falling or staying asleep ■ Irritability or outbursts of anger ■ Hypervigilance ■ Exaggerated startle ■ Craving to fight/defend ■ Tremor
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Slide courtesy of John Straznickas, M.D., VA San Francisco, 2009

What are the BIG Treatment Questions?

- Is abstinence or harm-reduction the more appropriate early goal?
- Sequential, parallel or integrated treatment?
- Is there really self-medication going on here?
- Is more re-experiencing preferred to better repression?

Dogma Eat Dogma





- Dogmas of addiction treatment need to be examined for effective care
 - *Dogma*: Avoid sleep medications.
 - *Dogma*: Marijuana is always a drug of addiction.
 - *Dogma*: Therapy/Insight is protective.
 - *Dogma*: Harm reduction approaches give up on patient-progress.

SUD/PTSD Treatment Models

- **Separate:**
 - Patients fall between the “cracks of care”
 - Consultative model (expert consultant)
- **Parallel :**
 - Concurrent care but different providers
 - Increased difficulties in therapeutic alliance
- **Sequential :**
 - SUD first, PTSD second
 - Do we lose patients due to untreated PTSD symptoms, such as sleep disorder or anger ?
- **Integrated :**
 - SUPT (Substance Use PTSD Treatment Team) Model in VA care
 - Is harm-reduction a viable initial goal?

Scylla and Charybdis: Odysseus, the Warrior, Coming Home

Hyper-Arousal ↔ vs. ↔ Numbing

<p><i>Over-generalization of Stimuli</i> <i>Fear & Startle Responses</i> <i>Anger & Rage</i> <i>Vigilance , Paranoid Trends</i> <i>Sleep Disorder</i></p> 	<p><i>Avoidance</i> <i>MJ & Drug Use</i> <i>Isolation</i> <i>Drinking</i></p> 
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Stimuli, Arousal, and PTSD

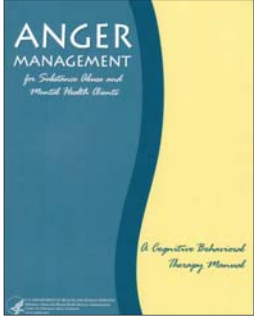
- Hyper-responsiveness to stimuli that are reminders of trauma/s
- Overgeneralization of stimuli
- Failure of Extinction of conditioned fear responses
- Anger Dyscontrol

Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual

Patrick M. Reilly, Ph.D.
Michael S. Shopshire, Ph.D.

2003

helps counselors teach anger management techniques in a group setting through a 12-week cognitive behavioral intervention (participants use the accompanying workbook). The manual describes the anger cycle, conflict resolution, assertiveness skills, and anger control plans.




Download at SAMHSA Website

Debates in Comorbidity

Primary Addiction
 Reward
 Genetics

vs.

Self-Medication
 De-Arousal
 Sleep



Alcohol & Risk Behaviors

- Accidents
- Violence
- Suicide



Alcoholisms are 40-60% Genetic



* ILLUSTRATION BY JONATHAN BARKER

Courtesy Sean McDonald/ENW

Debates in Comorbidity

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vs.

Self-Medication
 De-Arousal
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Sequential Treatment
 Baseline of Sobriety
 Stability

vs.

Simultaneous Treatment
 Harm Reduction
 Safety

Debates in Comorbidity

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 Harm Reduction
 Safety

Re-Experiencing
 Exposure, Remembering
 Integration

vs.

Repression
 Forgetting
 Adaptation

Repression vs. Remembering: Peter's Working Definition of PTSD

- The inability to successfully repress the trauma . . . and, thus "forget it."

Coupled with

- The inability to remember it fully enough . . . and, thus "work it through."

Reluctance of Addiction Therapists to initiate PTSD Treatment Early in SUD Treatment

- SUD patients may be cognitively impaired and unable to process their traumas using Prolonged Exposure or other “processing” protocols.
- Increased relapse risk from:
 - Negative affects
 - Arousal from trauma memories
 - Treatment drop-out
- Fear of SUD relapse from PTSD trauma work leads to separate or sequential tx approaches.

Reluctance of PTSD Patients (and Therapists) to Initiate SUD Treatment

- ‘Addict’ is a degraded identity for a warrior
- Interactive and public nature of SUD work
- Confrontation of addictive behaviors by treatment programs → increases arousal and/or hostility

12 Step Challenges in the Context of Combat PTSD

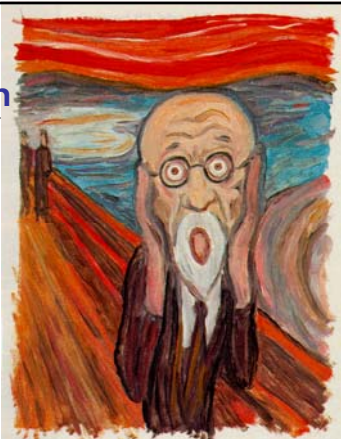
- Concepts of a ‘Higher Power’ and ‘Surrender’
- AA’s core tenet that life has become unmanageable and that they have ‘lost control’
- Fearless moral inventory and making amends
- AA’s crowd of strangers and the telling of ‘war’ stories

Slide courtesy of John Straznickas, M.D.

Rules of Thumb

- Ask the patient to teach you what you don’t know. Listen carefully, even if it violates your pre-conceptions.
- Consider structuring personal “research” trials of 4-6 weeks of abstinence/limited drinking for resistant drinkers.
- Try to help with disturbed sleep. Show some flexibility about medications.
- Pay attention to issues of strength vs. weakness (strength is a military virtue).
- Be prepared to work with moral issues such as harm-done and forgiveness.

Discussion



A Few Good . . . References

- Zaslav, Mark, *Psychology of Comorbid Posttraumatic Stress Disorder and Substance Abuse: Lessons from Combat Veterans*, J Psychoactive Drugs, Vol. 26, No. 4, 1994.
- Satel, Becker and Dan, *Reducing Obstacles to Affiliation with Alcoholics Anonymous Among Veterans with PTSD and Alcoholism*, Hosp and Community Psychiatry, Vol. 44, No. 11, 1993.
- McLeod, Koenen, Meyer, Lyons, Eisen, True and Goldberg, *Genetic and Environmental Influences on the Relationship Among Combat Exposure, Posttraumatic Stress Disorder Symptoms, and Alcohol Use*, J Traumatic Stress, Vol. 14, No. 2, 2001.
- Raskind et al., *Reduction of Nightmares and Other PTSD Symptoms in Combat Veterans by Prazosin: A Placebo-Controlled Study*, Am J Psychiatry, 160:2, February 2003.