



Trauma and Addiction

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Disclosures

- Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose.

Trauma and PTSD

- Trauma created by exposure to actual or threatened death, injury, or sexual violence
 - Can be direct personal experience or witnessed, to family member or close friend
- Symptoms include:
 - Recurrent, intrusive dreams or memories
 - Dissociative reactions, Intense reactions to cues
 - Avoidance of related stimuli
 - Alterations in cognition and mood
 - Increased arousal and reactivity

Complex Trauma and PTSD

- Characterized by
 - Multiple traumas over lifespan, chronic symptoms
 - Comorbid with substance use disorder
 - Early life trauma with repeat
 - Associated life stresses, e.g. homelessness, unemployment or underemployment, incomplete education

Complex Symptoms

- Complex trauma associated with more severe symptom expression (Hein, 2004)
 - Mood modulation, self-destructive behavior
 - Cognitive issues, dissociation, depersonalization
 - Increased association to somatic symptoms
 - Interpersonal symptoms, difficulty with intimacy and trust

Prevalence

- SUD and PTSD/trauma experience highly comorbid (Gialen, etal, 2012; VandenBrink, 2015)
 - General population estimates 4-8% meet PTSD criteria
 - SUD population estimates:
 - 25-50% lifetime PTSD diagnosis
 - 15-40% symptomatic during current year
 - PTSD patients seeking treatment
 - 20% meet criteria for substance use disorder

Why such high comorbidity?

- Such high comorbidity suggests a dynamic interaction
 - Self-medication?
 - Does PTSD increase likelihood for SUD?
 - Heightened risk?
 - Does SUD increase risk for traumatic experience?
 - Shared vulnerability?
 - Other common factors?

Commonalities

(Ruglass, etal, 2014)

- Shared attentional bias to threat
 - Related to both onset and maintenance
 - Cues drug use
- Anxiety sensitivity
 - Related to increased severity of both disorders
 - Associated to increased consumption and onset of new SUD dx in later years

Commonalities

(Ruglass, etal, 2014)

- Outcome expectancies
 - Expectation of negative outcome leads to increased likelihood of craving, seeking, frequency, and quantity of use
- Both conditions associated with changes in brain structure and function
 - Disruption of stress response via dopamine, norepinephrine, serotonin
 - Effects on stress management via Hypothalamic-adrenal-pituitary axis

Treatment Considerations

- SUD and Trauma/PTSD
 - Each with very serious cognitive, affective and behavioral manifestations
 - Many common aspects
- Possible treatment approaches –
 - Sequential: Treat SUD, then work on trauma symptoms if continue
 - Parallel: Treat simultaneously using separate evidence based protocols
 - Integrated: Treat both, addressing interaction

SUD vs Trauma/PTSD treatment

- Current standard of care, generally
 - SUD treatment only, or initially
 - Concerns that PTSD treatment will increase SUD risk
 - Concerns that patient won't be able to benefit from exposure tx
- Meta-analysis of past 15 yrs of research
 - SUD patients tolerate PTSD treatment without increased SUD, prefer simultaneous tx
 - Reduced PTSD symptoms lead to reduced SU

Treatment Approaches

- Behavioral
 - Present focused
 - Psycho-education, coping skills training, relapse prevention to manage symptoms
 - Past focused
 - Exposure based
 - Utilize modified exposure protocols
 - Combined
 - CBT + PTSD, e.g. Relapse prevention integrated with Prolonged Exposure

Treatment Approaches

- **Behavioral Treatment Protocols** (Najavits & Hein, 2013)
 - Concurrent Prolonged Exposure (COPE) (Mills et al, 2012)
 - Seeking Safety (Najavits, et al, 1988)
 - Women's Integrated Treatment (Covington, et al, 2008)
 - Integrated CBT for SUD and PTSD (ICBT) (McGovern et al, 2009)
 - Trauma Adaptive Recovery and Group Education (TARGET) (Frisman et al, 2008)
 - Trauma Empowerment and Recovery (TREM) (Toussaint, et al, 2007)
 - Helping Women Recover/Beyond Trauma (Messina et al, 2010)

Treatment Efficacy

- Mixed Results

(Najavits & Hein, 2013; Ruglass, et al, 2014; Van Dam, et al, 2012)

- Present focused, coping:

- Recent studies cast doubt on efficacy vs active treatment control groups
 - All groups improved similarly

- Past focused, exposure:

- As compared to active control, mixed results
 - Improvement, if at all, in PTSD symptoms, function and coping, cognition, self-compassion
 - No increased risk of relapse, but little improvement on SUD symptoms

Trauma Informed Care

- SAMHSA (2015) recommends shift to
Trauma informed approach
- Effort to address consequences of trauma
 - Systems that acknowledge both the broad impact of trauma, and the numerous paths to recovery
 - Recognizes the signs and symptoms of trauma for all parties involved including the system
 - Responds by developing policies, procedures and practices that reflect trauma awareness
 - Resists re-traumatization

Trauma Informed Care

- Utilizes trauma specific interventions, in combination with effective SUD treatment
- Key Principles
 - Safety
 - Trustworthiness and Transparency
 - Peer Support
 - Collaboration and mutuality
 - Empowerment, voice and choice
 - Cultural, Historical, and Gender Issues

A Long Road Ahead

- Increasing awareness of the broad based incidence and impact of substance use and trauma
leads to...
- Increased awareness of need for integrated treatment approaches
leads to...
- Increased consideration about how to adjust current treatment practice, policy and procedure to provide effective, compassionate care for clients.