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

- Memory Issues
- Shame/guilt
- Negative idea of self
- Sleep Issues
- Outbursts
- Concentration
- Situations
- People
- Conversation
- Memory Issues
- Shame/guilt
- Negative idea of self
- Relive Experience
- Avoid
- Arousal
- React
- Cognition
- Mood
Complex Trauma and PTSD

Multiple trauma over life
Trauma onset early in life

Associated social stresses:
- Homelessness
- Employment Issues
- Education Issues
- Social Support Issues
- Substance Use Issues

Mood modulation
Self-destructive behavior

Cognitive issues:
- Dissociation
- Loss of connection to self

Somatic symptoms

Relationship issues:
- Trust
- Intimacy
Prevalence

• SUD and PTSD/trauma experience highly comorbid (Gialen, et al, 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
# SUD and Trauma

<table>
<thead>
<tr>
<th>Opiate Use*</th>
<th>Cocaine Use**</th>
<th>Cannabis***</th>
<th>Alcohol****</th>
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</thead>
<tbody>
<tr>
<td>Associated with higher risk for PTSD</td>
<td>Estimated 8-43% of active cocaine users have PTSD</td>
<td>Risk of PTSD associated with lifetime risk of cannabis use</td>
<td>30-60% of Alcohol Use Dx (AUD) patients meet criteria for PTSD</td>
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<td>15-29% of Opiate users report PTSD symptoms over the lifetime (risk of PTSD lifetime 6-7% in general population)</td>
<td>23-42% of cocaine users report PTSD across the lifetime</td>
<td>Incidence rates of cannabis dependence up to 3x higher with PTSD dx</td>
<td>PTSD and AUD co-occur more commonly in men</td>
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<td>Rates tend to be higher for women and for those with childhood abuse hx</td>
<td>For youth, PTSD implicated in cannabis use onset</td>
<td>For those seeking treatment, co-occurrence up to 85%</td>
<td></td>
</tr>
</tbody>
</table>

**Citations**
*Himmelhoch, etal, 2012
**Saunders, etal, 2015
***Cougle, etal, 2011; Kilpatrick, etal, 2003; Cornelius, etal, 2010
****Ralevski, E,etal, 2014
Screening for Trauma

• **PTSD Checklist – Civilian Version**  (Lang, A.J., Stein, M.B. 2005)
  
  http://www.mirecc.va.gov/docs/visn6/3_PTSD_CheckList_and_Scoring.pdf
  
  - Developed for use in medical settings
  - Abbreviated version available for screening

• **PC-PTSD**
  
  http://www ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp
  
  - 4-item screen
  - Screen for PTSD in primary care, general medical settings
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, et al, 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, et al, 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: SUD, PTSD, SUD+PTSD?

1. Sequential
   - Treat SUD first
   - Treat PTSD if needed

2. Parallel
   - PTSD
   - SUD

3. Integrated Care
   - PTSD
   - SUD

www.mghcme.org
PTSD Treatment

• Evidence based treatment: 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

**Cognitive/Coping Skills**
- Seeking Safety (Najavits, et al, 1988)
- Integrated CBT for SUD and PTSD (McGovern et al, 2009)
- Trauma Adaptive Recovery and Group Education TARGET (Frisman et al, 2008)
- Trauma Empowerment and Recovery (Toussaint, et al, 2007)

**Integrated Approaches**
- Concurrent Prolonged Exposure COPE (Mills et al, 2012)
- Women’s Integrated Tx (Covington, et al, 2008)
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)
Coping Skills, Present Focused Tx:

  - Some studies cast doubt on efficacy vs active treatment control groups, e.g. Seeking Safety
    - All groups improved similarly
  - iCBT possibly more effective when added to standard SUD treatment (McGovern, et al, 2016)
    - In RCT, compared to Individualized Addiction Tx, iCBT associated with improved toxicology and reported drug use, better retention
Treatment Efficacy

• Exposure based, past focused approaches
  – Recommended by Institute of Medicine and SAMHSA as best evidence based tx.
    • As compared to active control, mixed results
    • Improvement, if at all, in PTSD symptoms, e.g. function and coping, cognition, self-compassion
    • No increased risk of relapse, but little improvement on SUD symptoms
    • EX: CPT modified to include SUD compared to iCBT (Haller, et al, 2016)
      – Both groups improved similarly
      – No differences in outcome at baseline and at 1 year follow up
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

• [http://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf](http://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf)
Trauma Informed Care

• Key Principles
  – Safety
  – Trustworthiness and Transparency
  – Peer Support
  – Collaboration and mutuality
  – Empowerment, voice and choice
  – Cultural, Historical, and Gender Issues

• Utilizes trauma specific interventions, in combination with effective SUD treatment
Barriers to Implementation
(Killeen, Back, & Brady, 2015)

• At the Organizational Level:
  – Limited resources to train and provide long term support for manualized treatment protocols
  – MH and SUD treatments offered in different settings with little cross-over
  – More likely in larger clinics with more private payor funding, affiliated with psychiatric services

• At the Provider Level:
  – Limited training in intensive therapies
  – Few resources for ongoing supervision
  – Secondary traumatic stress

• At the Patient Level:
  – Best if patient can choose therapy type; most prefer integrated care
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.