Treatment of Co-occurring Trauma/PTSD and Addiction

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Goals & Objectives

1. Understand the Disease Model of Addiction
2. Describe the continuum of PTSD/Trauma reactions and disorders
3. Identify and know the differences between at two evidence-based treatments for PTSD/Trauma

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Addiction and Trauma Disorders

What is Addiction?

A chronic and progressive brain disease.

Three primary symptoms of addiction

(1) desensitization of the reward circuits of the brain

(2) increased conditioned responses related to the substance an individual is dependent upon

(3) declining function of brain regions that facilitate decision making and self-regulation.

These themes are echoed throughout the neurobiological literature on addiction (Volkow, Koob, and McLellan, 2016)

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Addiction

- The Observable Signs/Symptoms of Addiction
  1. Tolerance – need to use more and more over time to get the same effect (or avoid withdrawal)
  2. Withdrawal – physical symptoms when substance is not available
  3. Loss of Control

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What is Trauma?

Symptoms
unexplained pain
sleep & eat disturbance
low energy
increased autonomic arousal
depression
fear
anxiety
panic
numbness
irritability
anger
feeling out of control
avoidance
distraction
decreased concentration
memory lapses
difficulty making decisions
compulsive behaviors
substance abuse
eating disorders
impulsive, self-destructive behaviors
dissociation
difficulty in relationships
isolation
withdrawal
social avoidance
sexual difficulties
sexual promiscuity
sexual anorexia
feeling threatened
feeling hostile
argumentative
flashbacks
nightmares
intrusive memories/thoughts
sudden flooding of emotion
avoidance of reminders of trauma
shame (I'm wrong)
hopelessness

PTSD

time limited event
discrete conditioned behavioral and biological responses to reminders of the trauma

diagnosis made based on: number & type of symptoms present

Symptom Clusters:
- Re-experiencing Symptoms
- Avoidance Behaviors
- Alterations in Mood/Cognition
- Arousal

COMPLEX PTSD

- emotion regulation difficulties: persistent sadness,, suicidal thoughts, explosive anger, inhibited anger
- consciousness: forgetting traumatic event reliving event, feeling detached from body, environment, others
- self perception: helplessness, shame unwarranted guilt, stigma, sense of being completely different from other human beings, feeling broken
- distorted perception of the perpetrator: attribution of total power to perpetrator, preoccupation with perpetrator, preoccupation with revenge.
- relationship with others: isolation, large-scale distrust, repeated search for a rescuer
- System of Meaning: loss of faith, despair, hopelessness

DEVELOPMENTAL TRAUMA DISORDER
- chronic long-term periods of abuse, neglect, in childhood
- neurological, emotional, and relational development is effected resulting in a system of internal disorganization
- Associated with multiple mental health issues and physical issues in adulthood
- As a child, developmental "adaptations" occur in the interest of survival, and getting other needs met

In adulthood, these individuals may have difficulties with:
- difficulty identifying emotions, physical sensations
- nervous system is "disorganized" unable to discern safety and danger
- desperate attempts to avoid abandonment and search for "love"
- intense emotional/behavioral reactions
- given pejorative labels "dramatic" "unstable" "needy" "manipulative"
- extreme dissociation
- self-destructive behavior to "punish" self and/or self regulate
- helplessness that leads to incapacitation and inability to take action to improve circumstances

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PTSD Statistics

- 70% of adults in the U.S. have experienced some type of traumatic event at least once in their lives. Up to 20% of these people develop PTSD.
- At any give time, about 8% of Americans meet criteria for a PTSD diagnosis.
- About 1 out of 10 women develop PTSD and women are about twice as likely as men to develop PTSD.

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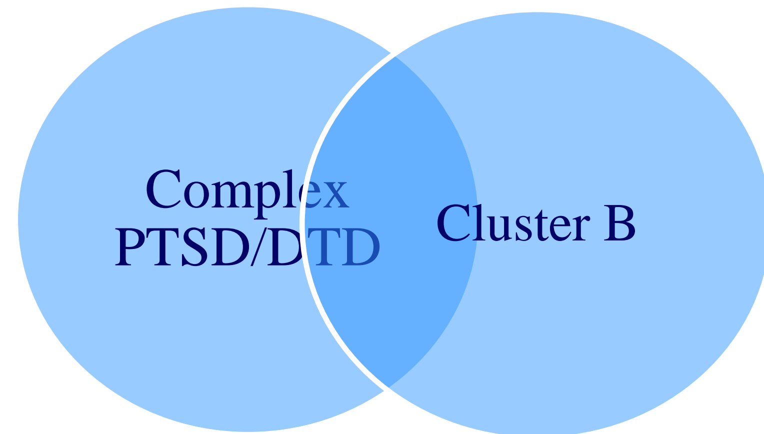
Complex PTSD Statistics

- No clear prevalence rates identified for Complex PTSD
- Look to rates of Cluster B disorders
  - BPD 1.6% to 5.9%
  - Histrionic 1.84%
  - Narcissistic up to 6.2%

Data from DSM-V, APA, 2015



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Reactions to trauma patients

"….traumatized people are frequently misdiagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete. Because of their characteristic difficulties with close relationships, they are vulnerable to become re-victimized by caregivers. They may become engaged in ongoing, destructive interactions, in which the medical and mental health system replicates the behavior of the abusers." (Herman, 1992)

Traumatic Stress Reactions

- "Quite routinely, what were initially normal reactions and adaptations to abnormal and recurring traumatic circumstances and experiences become problems over the long term because survival defenses are incompatible with a less dangerous or stressed life." (Courtois & Ford, 2013)

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Traumatic Stress Reactions

- "The behavioral and emotional adaptations that maltreated children make in order to survive are brilliant, creative solutions, and are personally costly."

(National Child Trauma Study Network)

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Trauma & The Brain

Something Happens…

THALAMUS
sensory information

AMYGDALA
safe/not safe

HYPOTHALAMUS
signals to release
stress hormones

We do something –
instinctual reaction

HIPPOCAMPUS
memory storage

PREFRONTAL
CORTEX
planful, goal-
directed, not
impulsive

We do something -
Thoughtful, planned response

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A Traumatized Brain

HYPOTHALAMUS
signals to release
stress hormones

We do something – instinctual reaction

AMYGDALA
safe/not safe

THALAMUS
sensory information

Something Happens…

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Which Came First?

1. *Shared Liability Model*
    1. PTSD & SUD share common genetic liability (Wolf, et al. 2010)
2. *Self Medication Theory*
    1. PTSD Symptoms lead to use of substances (Reed et al., 2007)
3. *High-Risk Hypothesis* (Chilcoat & Breslau, 1998; Acierno, et al., 1999).
    1. Causal link has not been fully supported in the research
4. *Susceptibility Hypothesis* (Jacobsen, et al., 2001)

Treatment Approaches

- Sequential Model of treatment
  - SUD is treated first
  - Trauma-focused treatment commences following sustained period of abstinence (3-6 mos)
- Integrated Model of treatment
  - Treat both disorders simultaneously
  - Linked with Self-Medication Hypothesis

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Treatment Approaches

- Sequential Approach
  - Minority of patients prefer this approach
- Integrated Model
  - Majority of patients prefer this approach
  - Superior outcomes in symptom reduction of both disorders

Integrated Treatments

- Non-Exposure based treatments
  - ATRIUM
  - TREM
  - Transcend
  - Seeking Safety
- Exposure-Based Treatments
  - Prolonged Exposure Therapy
  - Cognitive Processing Therapy

Exposure-Based Treatments

- Cognitive Processing Therapy (CPT)
- Prolonged Exposure Therapy (PE)

Phase Oriented Treatment of Traumatic Stress

- Why phase orientated treatment?
- Phase 1
- Phase 2
- Phase 3

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Phase Model: Phase 1

Phase 1: Safety, Stabilization, and Engagement

Safety

- Physical safety
- Emotional Safety

Stabilization/Engagement

- Symptoms may be debilitating and
- Negatively impact quality of life

Engagement in life and in therapy

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Phase Model: Phase 2

Phase 2: Trauma Memory and Emotional Processing

- Address features of traumatic stress disorders
  - Avoidance and Arousal
- Goals:
  - alter the approach/avoidance reactions
  - Address cognitive errors
  - Process memories and emotions related to the traumatic experience
  - Address loss, mourning, and grief
- Cognitive Processing Therapy (CPT) (targets frontal lobe via cognitive restructuring)
- Prolonged Exposure (PE) (targets amygdala via habituation)

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Phase Model: Phase 3

Phase 3: Application to Present and Future (Consolidating Therapeutic Gains)

- Goals:
  - Generalize therapy skills to "real world"
  - Consolidate therapeutic gains and move toward ending the treatment.
- Challenged to apply their new learning's to a nuanced and realistic understanding of their life options based on who they are and what they want.

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Integrated Model Challenges in a Time-Limited Residential Setting

- What can be accomplished in only 4-6 weeks of treatment?
- Emphasis of treatment…SUD, PTSD, Complex PTSD?
- How to properly assess SUD, PTSD, other comorbidity, acute/post-acute withdrawal?
- How to structure treatment to have the greatest impact?
- Can treatment be individualized?

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Proposed Model of Treatment

- Assessment
  - PCL-5, DES, psychological evaluation, ongoing observation/assessment
- Phase-Based Treatment
  - Phase I Group series (4-6 weeks)
  - Phase II Cognitive Processing Therapy (6 wks)
- Personalizing Treatment
  - Assess readiness, motivation
  - Individualizing Phasing

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Phase 1 Topics

1. Psychoeducation about trauma reactions
2. What is Safety?
3. Coping Skills Practice
4. Trauma and the Brain “You’re not Crazy!”
5. Trauma Bonding
6. Trauma Stuck Points

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Phase II

Cognitive Processing Therapy

- Time limited, evidence-based treatment for PTSD
- Group and Individual Protocols
- Studied in VA and civilian populations internationally
- Treatment recommended by ISTSS based on strength of research – "Gold Standard" of treatment for PTSD.

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Cognitive Processing Therapy

- Assumes a Natural Recovery Process for most of those exposed to traumatic event
- PTSD is a sign of being "stuck" which prevents Natural Recovery process from unfolding.
- Goal of CPT
  - Prevent Avoidance
  - Identify cognitive Stuck Points that serve to maintain arousal/reactivity and help client get "unstuck."

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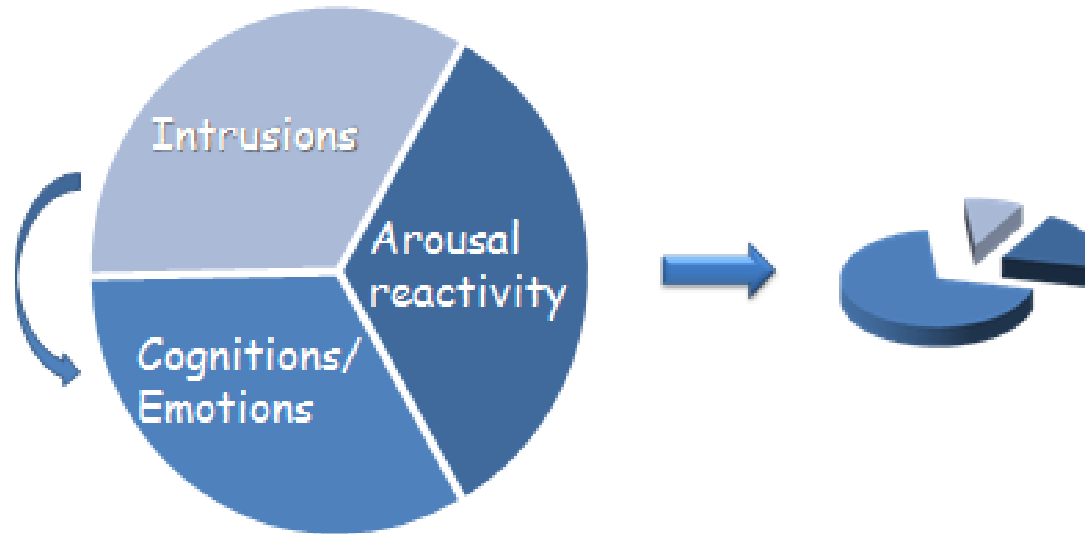
CBT Theory of PTSD

Normal Recovery Process

In normal recovery, intrusions and emotions decrease over time and no longer trigger each other



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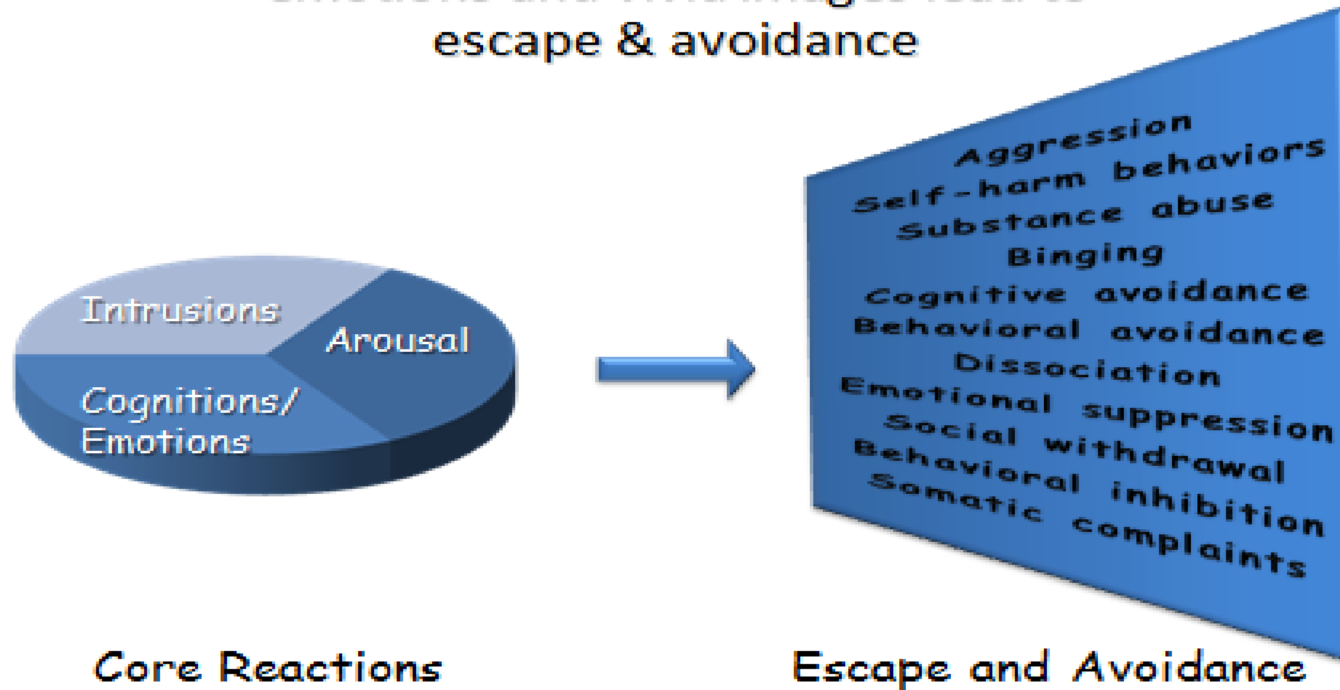
CBT Theory of PTSD

Development of PTSD – interference with Natural Recovery Process



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CPT Treatment

- CPT first challenges avoidance
- This leads to dissipation of natural emotions
- Changes in interpretation about the traumatic event changes manufactured emotions (e.g. shame, fear)
- Clients learn not to over-generalize their thinking about a single bad event to all people or themselves as people.

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Other Phase 2 Options: Prolonged Exposure Therapy

- Natural Recovery does not occur due to Avoidance of emotions/arousal
- Expectation develops that world and people are not safe.
- Through avoidance, the absence of anticipated harm reinforces that avoidance works.
- Avoidance prevents habituation to arousal
- Amygdala regulation is the target of this treatment.
- Exposure techniques (in vivo, imaginal) provide corrective learning and habituation to arousal.

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Phase 3

- Phases are not mutually exclusive nor are they linear
- Phase 3 can be incorporated throughout Phase 1 and 2 during residential treatment.

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