Treating substance use disorders and PTSD: Clinical considerations

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ROGERS Behavioral Health

1

Quick overview of logistics

Our speakers will give a 75-minute presentation.

Following the presentation, there will be a dedicated time to answer questions.

2

Disclosures

Sean LeNoue, MD, and **Lynsey Miron, PhD,** have each declared that s/he does not, nor does his/her family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation. Drs. LeNoue and Miron have each declared that s/he does not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

3

Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Describe at least one way adverse childhood experiences (ACEs) increase risk for subsequent PTSD and substance use disorders (SUD).
2. Identify at least two common misconceptions in the treatment of co-occurring PTSD and SUD.
3. List and describe at least two evidence-based treatment modalities for co-occurring PTSD and SUD.

4

What we'll cover in this webinar

Epidemiology
- Prevalence
- Adverse childhood experiences
- Prognosis

Risk pathways and assessment
- Co-occurring models
- Assessment of comorbidity

Treatment
- Common misconceptions
- Research findings
- Practice recommendations

5

Epidemiology

- Prevalence
- Adverse childhood experiences (ACEs)
- Prognosis

Q&A

Please use the Q&A feature to send your questions to the moderator.

6

Prevalence

Trauma
- Defined as exposure "to actual or threatened death, serious injury, or sexual violence" (APA, 2013)
- Psychological trauma typically defined by broader scope

Exposure to a traumatic event is common in the United States
(Kessler, 2000; Kessler et al., 1995; Kessler et al., 1999)
- In the U.S., 51.2% of women and 60.7% men report at least one lifetime trauma
- Witnessing significant injury/death (#1); involved in fire/flood/natural disaster (#2); life-threatening accident/assualt, gunshot, or fall (#3)

7

Prevalence

Posttraumatic Stress Disorder (PTSD)
- Adults (NCS, 2007)
  - Past year: 3.6% (5.2% females, 1.8% males)
  - Lifetime prevalence: 6.8%
- Adolescents (Merikangas et al., 2010)
  - Overall prevalence: 5%, 1.5% with severe impairment
    - Females: 8%, Males: 2.3%

8

Prevalence

Substance Use Disorders (SUDs)
(Merikangas et al., 2012)

- Adults (12-month prevalence)
  - Alcohol: 12%
  - Illicit drugs: 2-3%
- Adolescents (12-month prevalence)
  - Alcohol: 8%
  - Illicit drugs: 2-3%

Robert, 2019

9

Prevalence

Posttraumatic Stress Disorder (PTSD) + Substance Use Disorders (SUDs) (Korte et al., 2017)

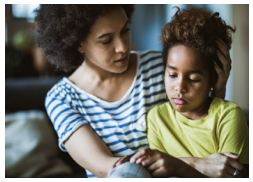
- HIGHLY comorbid
  - Approximately 50% individuals with PTSD also have a substance use disorder
  - Comorbidity associated with:
    - More severe PTSD symptoms
    - Increased risk for substance relapse after treatment

10

Prevalence

Adverse Childhood Experiences (ACEs)

- ACEs are COMMON
- Approximately 60% U.S. adults reported experiencing ACEs
- 1:6 reported ≥4 ACEs
- Women and racial/ethnic minority groups at greater risk ≥4 ACEs
- Increased risk for injury, STIs, teen pregnancy, sex trafficking, chronic illnesses, and suicide



CDC, 2019

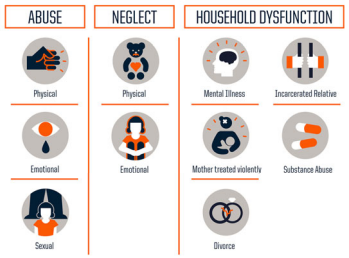
11

Impact on families, communities, and dreams…

12

Adverse Childhood Experiences (ACEs)

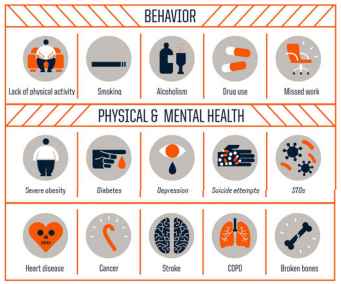
- Childhood experiences negatively impacting a person's well-being and often have lasting effects (Dube et al., 2005)
- Domestic violence, family member struggling with substance use and/or mental health concerns, child abuse/neglect



Hughes et al., 2017; Starecheski, 2015

13

Adverse Childhood Experiences (ACEs)



- Strong relationship between non-sexual child maltreatment and a range of mental disorders, drug use, suicide attempts, sexually transmitted infections, and risky sexual behavior.
- Histories of repeated victimization

(Norman et al., 2012)

Hughes et al., 2017; Starecheski, 2015

14

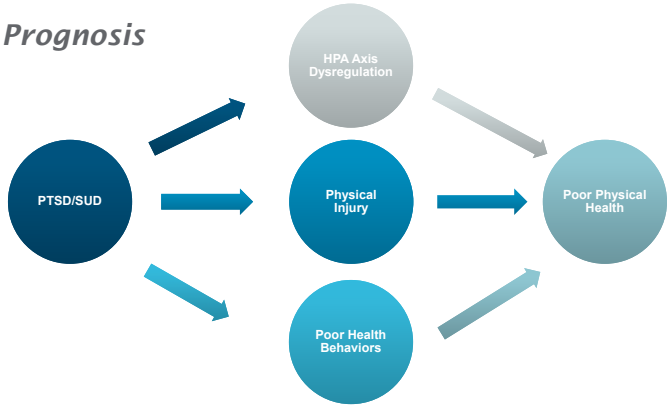
Prognosis

"Individuals with co-occurring SUD and PTSD suffer a more complicated course of treatment and less favorable treatment outcomes compared to individuals with either disorder alone."
(Flanagan et al., 2016)

- Increased chronic physical health problems
- Poorer social functioning
- Higher rates of SA
- More legal problems
- Increased risk of violence
- Worse treatment adherence
  (Flanagan et al., 2016)

15

Prognosis



Adapted from Vujanovic & Back, 2019.

16

Prognosis

- Complicated issues leading to complicated disorders that can be ***chronic, relapsing-remitting illnesses***
- Can be difficult to treat due to ***complex*** nature of illness
- Often take a ***multifaceted*** approach of possibly multiple psychotherapeutic modalities as well as possibly multiple medications CONCURRENTLY in order to effectively treat symptoms/issues

17

Risk pathways and assessment

- Co-occurring models
- Assessment of comorbidity

Q&A Please use the Q&A feature to send your questions to the moderator.

18

Risk pathways

Why do PTSD and SUDs co-occur? The reasons are complicated and multifaceted

Four common co-occurring models have been used to explain their relationship

Haller & Chassin, 2014

19

Co-occurring models

Self-medication model:

- Having PTSD makes someone more likely to develop a SUD because substances are used to manage symptoms

Shared liability and mutual maintenance model:

- There are shared reinforcing relationships between traumatic stress and SUDs that underlie and maintain both disorders

Chilcoat & Breslau, 1998; Lopez-Castro et al., 2015; Norman et al., 2012; Ouimette et al., 2010

20

Co-occurring models

Susceptibility model:

- Early stress exposure leading to PTSD makes people more vulnerable to develop SUDs later

High-risk model:

- Substance use or abuse increases risk for trauma exposure by placing individuals in high risk situations (e.g., drug-related crime) or impairing detection of danger cues in the environment

Davis et al., 2009; Haller & Chassin, 2014; Kendler et al., 2000; Young-Wolff et al., 2011

21

Co-occurring models

Most evidence for the **self-medication model:**

- PTSD has been shown to develop before SUD in most comorbid cases in retrospective studies
- PTSD has been shown to increase risk for SUDs in prospective studies

In one study, for each additional PTSD symptom, risk for alcohol and drug problems increased approximately 10%

Haller & Chassin, 2014; Hien et al, 2005; Stewart & Conrad, 2003

22

Co-occurring models

Models are not mutually exclusive and can be integrated into a larger, developmental model of PTSD-SUD comorbidity

- Additive impact of stigma and minority stress-specific triggers

High prevalence suggests a common etiological diathesis, including environmental and genetic factors

- High risk family context
- HPA-axis dysregulation (over-reactivity of the body's stress response to non-threatening situations)

López-Castro et al., 2015; Norman et al., 2012; Rojas et al., 2019

23

Assessment of comorbidity

The thorough assessment of symptoms is an essential component of the effective treatment of PTSD and SUD

Primary goals of assessment:

- Detection of trauma exposure and problematic substance use behaviors
- Evaluation of DSM-5 diagnoses
- Ongoing assessment of symptom severity during treatment

McCauley et al., 2012

24

Assessment of comorbidity

Initial screening (SUD):

- Alcohol Use Disorders Identification Test (AUDIT)
- Drug Abuse Screening Test (DAST)
- Biological tests for alcohol and drug use (e.g., urinalysis)

Initial screening (PTSD):

- Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)
- PTSD Checklist for DSM-5 (PCL-5)

Gavin et al., 1989; Prins et al., 2016; Saunders et al., 1993; Weathers et al., 2013b

25

Assessment of comorbidity

Diagnostic interviews:

- Clinician Administered PTSD Scale for DSM-5 (CAPS-5)
- Alcohol Use Disorders and Associated Disabilities Interview Schedule-5 (AUDADIS-5)
- Structured Clinical Interview for DSM-5 (SCID-5)
- Mini International Neuropsychiatric Interview (MINI)

First et al., 2016; Grant et al., 2015; Sheehan et al., 1998; Weathers et al., 2013a

26

Assessment of comorbidity

Symptom severity and treatment tracking:

- PTSD Checklist for DSM-5 (PCL-5)
- Timeline Followback (TLFB)
- Brief Addiction Monitor (BAM)
- Ongoing biological screening

Cacciola et al., 2010; Sobell & Sobell, 1995; Weathers et al., 2013b

27

Treatment

- Common misconceptions
- Research findings
- Practice recommendations

Q&A

Please use the Q&A feature to send your questions to the moderator.

28

Common misconceptions

1. *If I ask a co-occurring patient about their trauma, they are going to relapse and get worse*
2. *Patients will not benefit from trauma treatment unless they abstain completely from substance use*
3. *Patients with co-occurring PTSD/SUD do not respond well to treatment*

29

Treatment: Research findings

Historically, the standard of care has been to treat the SUD first and defer treatment of PTSD (**sequential model of treatment**)

- Research now suggests that this is not necessary or preferred
- Few patients (under 30%) prefer this model

Some effective treatments address PTSD and SUD at the same time, and others address PTSD and SUD individually

- Integrated approaches are fast becoming preferred and recommended

McCauley et al., 2012; Roberts et al., 2015

30

Treatment: Research findings

Integrated models of treatment acknowledge the interplay between symptoms of PTSD and SUDs

- Both disorders targeted by the same clinician/team
- More closely linked with the **self-medication hypothesis**
- Theorizes that providing relief from PTSD symptoms will likely improve recovery from SUDs
- Preferred by the majority of patients

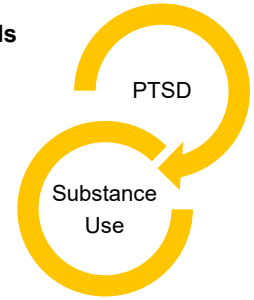
McCauley et al., 2012; Roberts et al., 2015

31

Treatment: Research findings

Research supports integrated models

- When PTSD symptoms get better, problems related to substance use usually get better
- The reverse is not true: when substance use gets better, PTSD does not generally get better
- ***Trauma treatment should not be delayed***



Back et al., 2006; Hien et al., 2010; McCauley et al., 2012; Roberts et al., 2015

32

Practice recommendations

Integrated treatment options for PTSD/SUD:

- Concurrent Treatment of PTSD and Substance Use Disorders using Prolonged Exposure (COPE)
- Seeking Safety
- Integrated Cognitive Behavioral Therapy (ICBT)

Less formalized approaches to integration also have utility

Back et al, 2019; Capone et al., 2014; McCauley et al., 2012; Najavits, 2002

33

Practice recommendations

Simpson et al. (2017): review of RCTs that evaluated treatments for comorbid PTSD/SUD

- Participants benefitted from nearly all treatments tested, including standard SUD care
- **Integrated exposure-based treatment and behavioral SUD treatment recommended, when available**

34

Practice recommendations

Meet patients where they are:

- Some patients will be interested in abstinence and some patients will be interested in reducing use
- Goals may vary across different substances used
- Drug screening should be used as a tool to reward success, not police

Trust and rapport are essential

Harm Reduction

- Something is better than nothing (when it comes to progress).

35

Practice recommendations

Multifaceted treatment approach is often needed for therapy and medications

- Gold-standard treatment for moderate to severe symptoms is often the combination of psychotherapy with medications (Flanagan et al., 2016)
- Therapy: CBT/PE
- Medications
  - Selective Serotonin Reuptake Inhibitors (SSRIs)
  - Recovery Medications

Slow and steady…These issues take time to treat

36

Time for questions and answers…

37

Where to get additional information…

SAMHSA
Substance Abuse and Mental Health Services Administration

Substance Abuse and Mental Health Services Administration
samhsa.gov

U.S. Department of Veterans Affairs

US Department of Veterans Affairs (VA) National Center for PTSD
ptsd.va.gov

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Centers for Disease Control and Prevention (CDC) Preventing Adverse Childhood Experiences
cdc.gov/violenceprevention/pdf/preventingACES.pdf

38

About the presenters…

Sean LeNoue, MD
Attending Physician, Nashville
Dr. LeNoue is a child/adolescent, adult, and addiction psychiatrist at Rogers Nashville location who treats patients with co-occurring mental health and substance use disorders. He is a member of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine, and the American Academy of Addiction Psychiatry.

Lynsey Miron, PhD, LP
Clinical Supervisor, St. Paul
Dr. Miron is a licensed clinical psychologist and serves as the clinical supervisor for the adult and child and adolescent partial hospitalization and intensive outpatient programs at Rogers Behavioral Health in St. Paul, Minnesota. Dr. Miron provides training and supervision that promotes evidenced-based treatments for OCD, anxiety, depression, PTSD, and substance use disorders

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39