CRAIG LODIS, PHD

FACILITATING DIFFICULT CONVERSATIONS ABOUT TRAUMA WITH SUD CLIENTS

None of the planners or presenters for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

OBJECTIVES

- Brief review of DMS-V diagnostic criteria
- Explore the physiological and cognitive impacts of PTSD and how they relate to increased susceptibility to SUDs
- Brief description of EBTs for PTSD and co-morbid SUDs
- Discuss integral role of avoidance in maintaining PTSD symptom levels
- Explore various difficult conversations and ways to approach them in the therapy room

Project ECHO®

University of Idaho
WWAMI Medical Education

WHAT IS TRAUMA?

Project ECHO®

University of Idaho
WWAMI Medical Education

TRAUMA ACCORDING TO THE DSM

- DSM-V defines a traumatic event (Criterion A in diagnostic criteria) as: “Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
  - Directly experiencing the traumatic events(s)
  - Witnessing in person, the event(s) as it occurred to others
  - Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
  - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)
    - Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures unless the exposure is work related.

PTSD CRITERIA SHORT-FORM

- Criterion A: Exposure to traumatic event(s)
- Criterion B: Re-experiencing symptoms
- Criterion C: **Avoidance** symptoms
- Criterion D: Negative alterations in cognitions and mood
- Criterion E: Increased arousal and autonomic reactivity

AVOIDANCE

- This is a core symptom
- Avoidance maintains and/or exacerbates PTSD symptoms
- Avoidance is the primary target of EBTs for PTSD

AVOIDANCE

- In terms of “difficult conversations” in treating PTSD and SUD, the role of avoidance and questioning the function of various behaviors should be a throughline in all of our clinical conversations.

PTSD AND SUDS

- Epidemiologic data indicate that individuals with, as compared to individuals without, an SUD are 6.5 times more likely to have comorbid PTSD (Mills, Teeson, Ross, & Peters, 2006)

- Comorbid SUD/PTSD is associated with substantial psychiatric comorbidity (e.g., depression), medical problems, vocational impairment, increased violence, and poor treatment outcomes (Barrett, Teeson, & Mills, 2014; Simpson, Lehavot, & Petrakis, 2017; Stein et al., 2017)

PTSD AND SUDS

- Up to 45% of patients with SUD experience comorbid PTSD (Dore, Mills, Murray, Teeson, & Farrugia, 2012)

- Among patients seeking treatment for SUD, lifetime PTSD rates have been found to range from 30% to 60% (Back et al., 2000; Brady, Back & Coffey, 2004; Jacobsen et al., 2001; McCauley, Killeen, Gors, Brady & Back, 2012)

WHY IS PTSD ASSOCIATED WITH INCREASED RISK FOR SUDS…

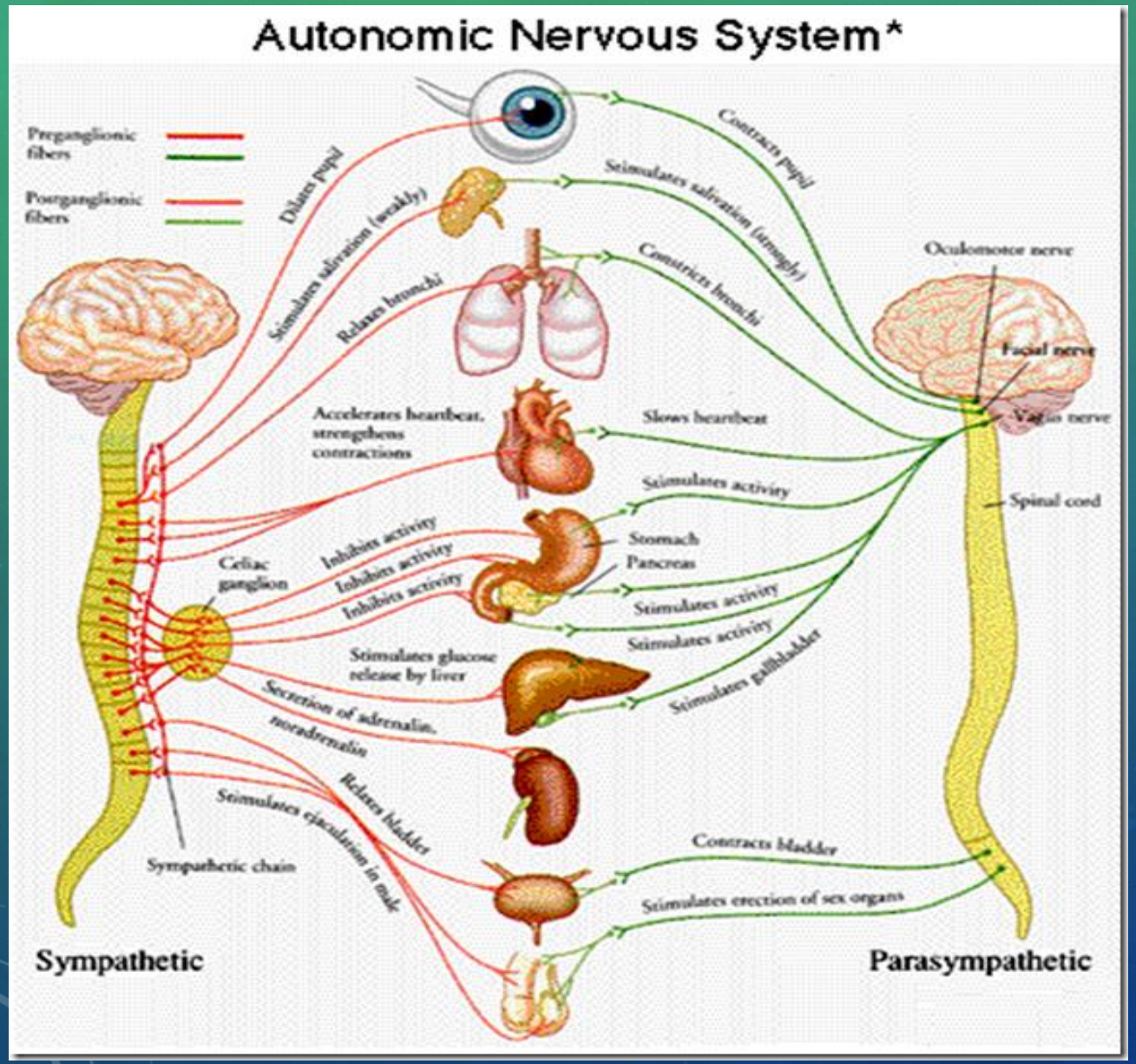
- Substance use can be conceptualized as a form of avoidance. In the short-term avoidance feels like it works (through the process of negative reinforcement).
  - *Whiteboard example….**

- Trauma can significantly impact our beliefs about *ourselves*, *others* and *the world* in the following areas:
    - Safety
    - Trust
    - Esteem
    - Intimacy
    - Power/Control

AUTONOMIC NERVOUS SYSTEM BASICS

- Our ANS controls our F/F/F response, which is basically like an alarm system for our body

- F/F/F response is automatic, meaning it is not under conscious control



80% of the nerve fibers that comprise the Vagus Nerve are **afferent** meaning they carry information from the body to the brain

20% of these nerve fibers are efferent (brain to body)

Project ECHO®

University of Idaho
WWAMI Medical Education

BRANCHES OF THE ANS

- Parasympathetic – parasympathetic activation is associated with rest, relaxation and digestion. If we sense safety parasympathetic activity will allow us to settle in and relax.

- Sympathetic – sympathetic activation is associated with mobilization (Fight/Flight/Freeze response). If we sense danger sympathetic activity will mobilize us for action.

- Individuals diagnosed with PTSD tend to exhibit increased sympathetic activation and decreased or inhibited parasympathetic activation.

- Car analogy…

AUTONOMIC NERVOUS SYSTEM

- PTSD decreases the amount of perceived threat it takes to set off our body's alarm system (i.e., a very sensitive alarm)

- This leads to numerous "false" alarms where there is not an objective threat. However, these alarms feel ***very real*** to our brain and our body

TREATMENT

- Thankfully there are numerous Evidence-Based Treatments for PTSD including:

  - Prolonged Exposure (PE)
  - Cognitive Processing Therapy (CPT)
  - Eye Movement Desensitization and Reprocessing (EMDR)
  - Written Exposure Therapy (WET)
  - Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE)

- Many of these treatments share two critical components that are thought to be responsible for the successful treatment of PTSD symptoms:

  - **Therapeutic exposure** – patients repeatedly confront internal stimuli (e.g., memories, sensations) and/or external stimuli (e.g., contextual) trauma reminders until they no longer experience clinically significant distress associated with these reminders. *(habituation vs. inhibitory learning?)*

  - **Cognitive therapy/cognitive restructuring** – in cognitive therapy for PTSD, cognitions, emotions, and meanings related to a given traumatic event are examined.

TREATMENT

- Depending on trauma history (i.e., chronic versus acute, childhood versus adult trauma) DBT skills are often an integral piece of treatment process.
  - Mindfulness
  - Emotion regulation
  - Distress tolerance
  - Interpersonal Effectiveness
  - STAIR (Skills Training in Affective and Interpersonal Relationships) is also another useful treatment protocol for PTSD.

TREATMENT

- A note on the notion of “re-traumatization” in the treatment of PTSD.

- Re-experiencing, avoidance and arousal hallmark symptoms of PTSD. If our patients meet criteria for PTSD it means they are experiencing these symptoms (likely on a frequent or even daily basis)

- Clinician’s own anxiety and apprehension will be picked up and thrown into the complicated feedback loop of interpersonal communication. We may inadvertently reinforce avoidance.

TREATMENT

- “Despite extensive research demonstrating the ability of PE to significantly reduce PTSD symptoms severity (Powers, Halpren, Ferenschak, Gillihan, & Foa, 2010; Resick, Williams, Suvak, Monson, & Gradus, 2012), some clinicians are reluctant to engage in exposure-based trauma work with SUD patients (Norman & Hamblen, 2017) and the vast majority of RCTs of treatments for PTSD exclude participants with SUD (Leeman et al., 2017).

- Accumulating evidence demonstrates, however, that PE is safe and associated with significant reductions in SUD severity, even among individual with complex trauma histories (Foa et al., 2013, 2017; Mills et al., 2012; Norman et al., 2016; Peck, Schumacher, Stasiewicz, & Coffey, 2018; Pesson et al., 2017; Ruglass et al., 2017).

HOW TO TALK ABOUT TRAUMA

- How much should we encourage patient to share regarding details of the trauma?
- What should patients know about typical treatment trajectory?
- Do patients need to be sober to engage in EBTs for PTSD?
- How can we manage our own anxiety and apprehension related to engaging in trauma work?

HOW MUCH SHOULD WE ENCOURAGE PATIENT TO SHARE REGARDING DETAILS OF THE TRAUMA?

- Leave it up to the patient how much they want to share regarding details of the trauma

- Make it clear that repeated (e.g., weekly) exposure-based interventions are going to be most helpful rather than talking about it once and then regressing back into avoidance

HOW MUCH SHOULD WE ENCOURAGE PATIENT TO SHARE REGARDING DETAILS OF THE TRAUMA?

- Sometimes disclosing details of the trauma and reconnecting with these memories just one time in session (e.g., in an intake or outside an agreement to do an EBT for PTSD) can actually be detrimental and inadvertently reinforce avoidance.

- Think of jumping into a cold lake *versus* slowly wading in and then running back to a warm fire…

WHAT SHOULD PATIENTS KNOW ABOUT TYPICAL TREATMENT TRAJECTORY?

- Patients deserve to know what to expect from treatment (broadly speaking)
- Explaining that often, not always, but often symptom levels will increase for the first few sessions before they plateau and then start to decrease.
  - Whiteboard example 2…*
- Patients should also be encouraged to scheduled PTSD sessions at the end of a workday, day off, or a day where they are able to have at least 1-2 hours of free time following the session.

DO PATIENTS NEED TO BE SOBER TO ENGAGE IN EBTS FOR PTSD?

- They do not need to be completely abstinent from substances. Making this a requirement may be creating an insurmountable barrier for some.

- I would be concerned about daily use in context of PTSD treatment. This is an area where we should use our clinical judgement and consult with other providers as needed.

DO PATIENTS NEED TO BE SOBER TO ENGAGE IN EBTS FOR PTSD?

- Patients must agree *not* to attend sessions under the influence.
- Patients must also agree to abstain from their substance of use for at least 2 hours after EBT for PTSD sessions.

HOW CAN WE MANAGE OUR OWN ANXIETY AND APPREHENSION RELATED TO ENGAGING IN TRAUMA WORK?

- If you have not received training in EBTs for PTSD seek supervision.
- If you are not comfortable doing PTSD work, refer out.
- Seek consultation and support from other colleagues.
- Practice what we preach! (e.g., self-care, therapy, etc.)

Project ECHO®

University of Idaho
WWAMI Medical Education

THERAPEUTIC POSTURE AND USE OF MI

- Always strive to offer our patients unconditional positive regard.
- Offer patients an option of menus and give them the autonomy to choose what works best for them in this moment in their lives
- When avoidance interferes call it out (this can be a difficult balance to strike), or at the very least encourage patient to consider potential role of avoidance

THERAPEUTIC POSTURE AND USE OF MI

- Ask permission to give advice or offer your interpretation
- Connect to values and reasons for wanting to make a change (pain with a purpose)
- Ask what life could look like 5 years from now if they make a change versus make no changes

RESOURCES

- The National Child Traumatic Stress Network | (nctsn.org)
- PTSD: National Center for PTSD Home (va.gov)
- Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE): Patient Workbook - Oxford Clinical Psychology

RESOURCES

- “Your Body Keeps the Score” by Bessel Van Der Kolk, MD
- “Trauma is Really Strange” a comic book style book of illustrations and explanations of trauma by Steve Haines
- How Childhood Trauma Leads to Addiction - Gabor Maté - Bing video