

PTSD and Substance Abuse

George Mangual
MSW, LPC, CADC II

Background

- A large number of clients in substance abuse treatment have current posttraumatic stress disorder (PTSD), estimated at:
 - 33-59% in women
 - 12-34% in men.

The majority have a history of trauma and often multiple traumas, such as child abuse, rape, criminal assault, serious accidents, natural disasters and combat

- Messages in substance abuse treatment such as “Don’t work on the PTSD until you’ve been clean for a year” or “Substance abuse is the only problems you need to focus on” , while well-intentioned, can be perceived as invalidating of clients’ trauma history.

- When a client who has PTSD is getting clean and sober a common phenomenon is for PTSD memories and feelings to worsen.

- Similarly, in the mental health field, messages such as “We can’t treat you if you have a substance abuse problem” or more commonly, neglecting to even ask about addiction, have left clients with inadequate attention to their substance abuse.

- Treating PTSD and substance abuse at the same time appears to help clients with their substance abuse at the same time appears to help clients with their substance abuse recovery, rather than derailing them from attaining abstinence.

- Early recovery treatment should focus on stabilization and safety for both PTSD and substance abuse.
- Assessment, diagnosis and treatment:
 - The sooner the better

Perspectives: Current-PTSD/SUD

- PTSD some possible contributing factors:
 - Developmental:
 - Early childhood abuse
 - Dysfunctional family dynamics/behaviors
 - Alcoholic/drug-abusing parents
 - Poor social supports
 - Current:
 - Dysfunctional family dynamics/behaviors
 - Lack of/poor social supports
 - Life stressor
 - Stress level

PTSD/SUD: Co-occur

- PTSD/SUD co-occur at a relatively high rate
- This co-occurrence is anticipatory of a more severe course
- Presence of either alone increases the risk of the other
 - Presence of Trauma associated with the development of SUD
 - People with PTSD/SUD are vulnerable to repeated traumas
- Consistently found to be co-morbid regardless of the nature of the trauma

PTSD/SUD: Complex Relationship

- PTSD/SUD patients experience greater impairment:
 - Other comorbid Axis I disorders
 - Interpersonal problems
 - Medical problems (e.g. cardiovascular, HIV, Hep)
 - Decreased motivation for treatment
 - High levels of anger and inappropriate coping
 - Trouble with law enforcement/courts
 - Domestic problems/violence/child abuse
 - Trouble getting/holding jobs
 - Increased homelessness

Substance Use: Functions

- Improve sleep
- Reduce physical pain
- Increase positive emotions
- “Numb” oneself to traumatic memories, emotions, or situations
- Escape distressing/feared emotions
- Increase a “false sense” of ability to cope
- Increase “socializing” and camaraderie

SUD: Treatment-General

- May need intensive case management
- Difficult to predict course of recovery
- May have multiple crises, or relapses
- May display erratic attendance
- Minimize exposure to triggers
- Groups helpful
- Tap into supports (e.g. family, community)
- Institute positive activities and new activities
- Tap into patient strengths,
- Model optimism, and develop patient's coping skills and resilience

- Many treatment programs are now including tobacco cessation with the use of nicotine replacement patches and an antidepressant. The antidepressant is prescribed and the client exits treatment with minimized depressive symptoms. Once the treatment regimen for the tobacco is completed, starts to experience depressive symptoms and/or anxiety; associating the symptoms as a post residential treatment symptom, not associating it with it's initial use of tobacco cessation.

- Clients with the dual diagnosis of PTSD and substance abuse have worse outcomes than those with either or alone and may internalize a sense of failure when they do not succeed in standard treatment programs that work for others. Feeling crazy or bad is common - a sense of demoralization, self-blame and feeling of something terribly wrong with them.

Seeking Safety Approach

- Present-focused, coping skills approach developed as an integrated treatment for PTSD/substance abuse for both disorders in early recovery.
 - Can be combined with trauma processing methods.
 - Can be used with both genders, individual or group and in a variety of settings (inpatient and outpatient)

Core Principles of Seeking Safety

- Safety as the priority of treatment.
- Integrated treatment of PTSD and substance abuse
- A focus on ideals
- Four content areas; cognitive, behavioral, interpersonal, and case management
- Attention to clinician processes – compassion, coping skills, give patient control whenever possible, client feedback about process, praise and accountability.

Outcome Studies

- Improvements were found in substance abuse as well as general psychiatric symptoms, suicidal thoughts and plans, problem-solving ability, sense of meaning, social adjustment and depression. (most of clients were substance-dependent and those addressing PTSD showed most having childhood and multiple traumatizations; typically had additional co-occurring Axis I and II disorders.

How are clients selected for treatment

- Client wish to participate in treatment
 - Empowerment is key (loss of power with PTSD and substance abuse)
 - Allow them to attend a few sessions

Since treatment is focused on safety, coping, and stabilization, treatment is not likely to destabilize client

Formats Applicable

- Effective in both group and individual formats
- Effective with women and men; outpatient and inpatient; open and closed groups; singly or co-led groups.

ASAM Patient Placement Criteria

Patient Placement Criteria Grid					
DIMENSIONS	EARLY INTERVENTION	OUTPATIENT	INTENSIVE OUTPATIENT	RESIDENTIAL	MEDICALLY MANAGED
WITHDRAWAL	No significant risk	No significant risk	No significant risk	No significant risk	Significant withdrawal risk
BIOMEDICAL	If biomedical problems, non-interfering	If biomedical problems, non-interfering	If biomedical problems, non-interfering	If biomedical problems, non-interfering	Requires 24 hrs medical/nursing care
EMOTIONAL/ BEHAVIORAL	If emotional/behavior problems, non-interfering	If emotional/behavior problems, requires minimal structure and support	If emotional/behavior problems, requires minimal structure and support	Alcohol Dependent emotional/behavioral problems interfere, require Milieu setting	Severe problems, require 24 hrs psychiatric care
PROGRAM/ TREATMENT ACCEPTANCE	Willing to participate	Motivated and/or willing to cooperate	Acknowledges problem. Requires monitoring/ motivation	Acknowledges problem. Requires Milieu setting	N/A
RELAPSE POTENTIAL	Able to achieve program goals in an educational setting	Able to maintain abstinence and achieve treatment goals with minimal support & structure	Able to maintain abstinence and achieve treatment goals with close monitoring & support	High likelihood of use without close monitoring in a Milieu setting	N/A
RECOVERY ENVIRONMENT	Supportive environment and/or skills to cope	Supportive environment and/or skills to cope	Coping skills and/or recovery environment requires additional support	Unable to cope with recovery environment, needs Milieu setting	N/A
OPERATIONAL COMMITMENTS	N/A	Command willing to commit to treatment requirements	Command willing to commit to treatment requirements	Schedule does not allow participation in another treatment program at this time	N/A

Challenges to Providing Substance Abuse Services with PTSD

- Case Management between MHU and SACC
- Clients on pain management medication and the use of benzodiazepines