

# Mental Health Colloquium

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# Clinical Innovations in Substance Abuse Treatment

Substance Use D/Posttraumatic Stress Disorder  
(SUD/PTSD)

# Moving from Dichotomous towards Dialectic treatment

How we think about SUD/PTSD matters

# SUPT: SUDs & PTSD Treatment Team



# Distress after trauma



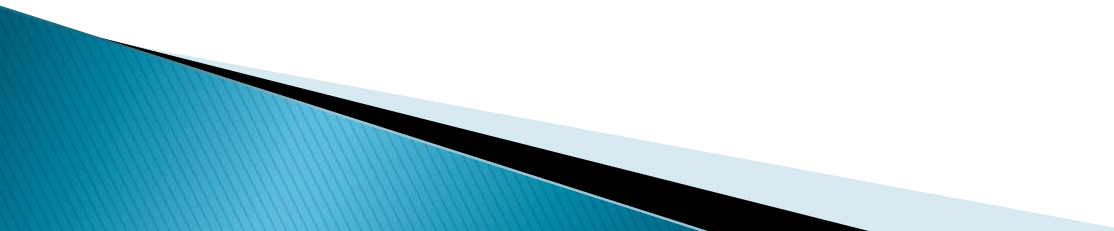
# Substances were a barrier 'home' 3000 years ago!



# SUD/PTSD Civilian Epidemiology

- ▶ SUD in civilian population without PTSD – lifetime prevalence 8%–24%
- ▶ SUD in civilian population with PTSD – 21% to 43%
- Kessler et. al. 1995, Breslau et.al. 1997

# High Co-occurrence of SUD/PTSD

- ▶ Look for PTSD in all your SUD patients.
    - Intrusions – NMs – 1
    - Avoidance – isolation, numbness, cue avoidance – 3
    - Hyper-arousal – Insomnia, irritability – 2
  - ▶ These symptoms get worse in early sobriety.
  - ▶ Don't confuse avoidance symptoms with resistance
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# SUD/PTSD Take Home Points

- ▶ **Complex, Counter tx & Crisis-prone Condition**
  - Expect more crisis management, relapse and intensification of treatment structures @ times
  - Make relationships with collateral supports
  - Don't blame them or yourself for poor outcomes
- ▶ **Expect an erratic and labile therapeutic alliance**
  - May take multiple & flexible treatment contacts before an effective alliance develops

# Dichotomous Thinking

- **Maladaptive cognitive habit.**
  - Extreme, mutually exclusive & inconsistent evaluations
    - Black/White, All/None thinking
- Cognitively generates extreme emotional reactions/treatment responses

# Dialectic Thinking

- ▶ Assumes a fundamental interrelatedness or wholeness of reality.
- ▶ Reality is a balance between opposing forces out of whose synthesis a new set of opposing forces emerge.
- ▶ The fundamental reality of nature is **change and process** rather than content and structure.
  - Socrates/Kant/Hegel/Fichte
  - Marsha Linehan Ph.D.

# Interrelated clinical syndromes

- ▶ **Intrusions – Cravings**
- ▶ **Hyper-arousal – w/d**
- ▶ **Loss of goal-oriented behaviors -> drug seeking behavior-> psychosocial conseq**
- ▶ **Intrusions – NMs**
- ▶ **Hyper-arousal – irritability, insomnia**
- ▶ **Loss of goal-oriented behaviors -> avoidance isolation behaviors-> psychosocial conseq**

SUD

PTSD

# Similar Neurobiologic abnormalities in SUD & PTSD

- ▶ Deficits in titrating level of arousal
  - Disease exacerbation with increased stress
    - SUD relapse,
    - PTSD intrusions, insomnia
- ▶ Cue-induced symptom exacerbation
  - SUD – “People, places and things” → use drugs
  - PTSD – “Activities, places and people” → avoid risk

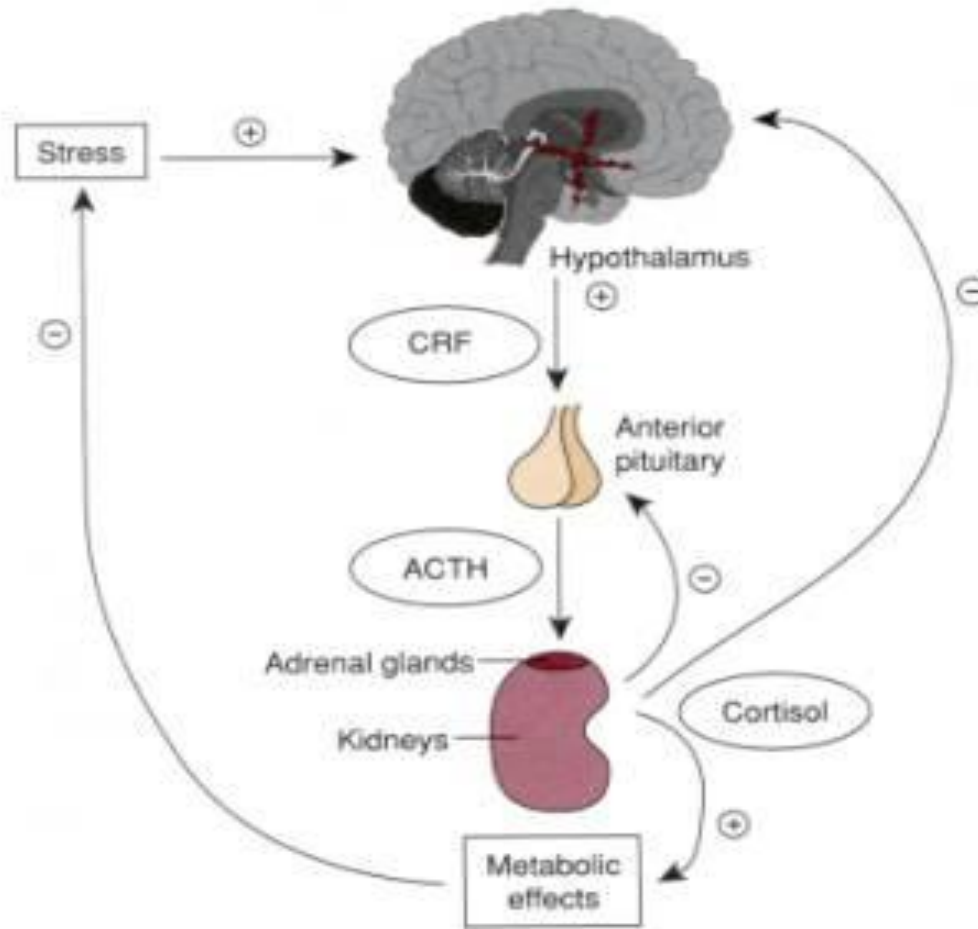
# More difficult to treat and poorer outcomes with SUD/PTSD patients

- ▶ Fewer clinical improvements, more crises
- ▶ **Uneasy tx alliance**, negative counter–tranx
- ▶ Poorer compliance with aftercare
- ▶ Shorter time to relapse post treatment
- ▶ Increased medical and interpersonal prob.
- ▶ Drink more on drinking days
- ▶ Increased rates of homelessness
- ▶ Druley and Pashko 1988, Nace 1988, Brown and Wolfe 1994, Saladin et. al. 1995, Breslau et. al. 1997, Ouimette et. al. 1999, Najavits 1998

# Why the difficulties and poorer outcomes.

A Double Dose of Distressed HPA Axis  
Mis-wired Limbic System  
Dichotomous Dogma

# Hypothalamic–Pituitary–Adrenal Axis – Regulates ‘stress’ responses



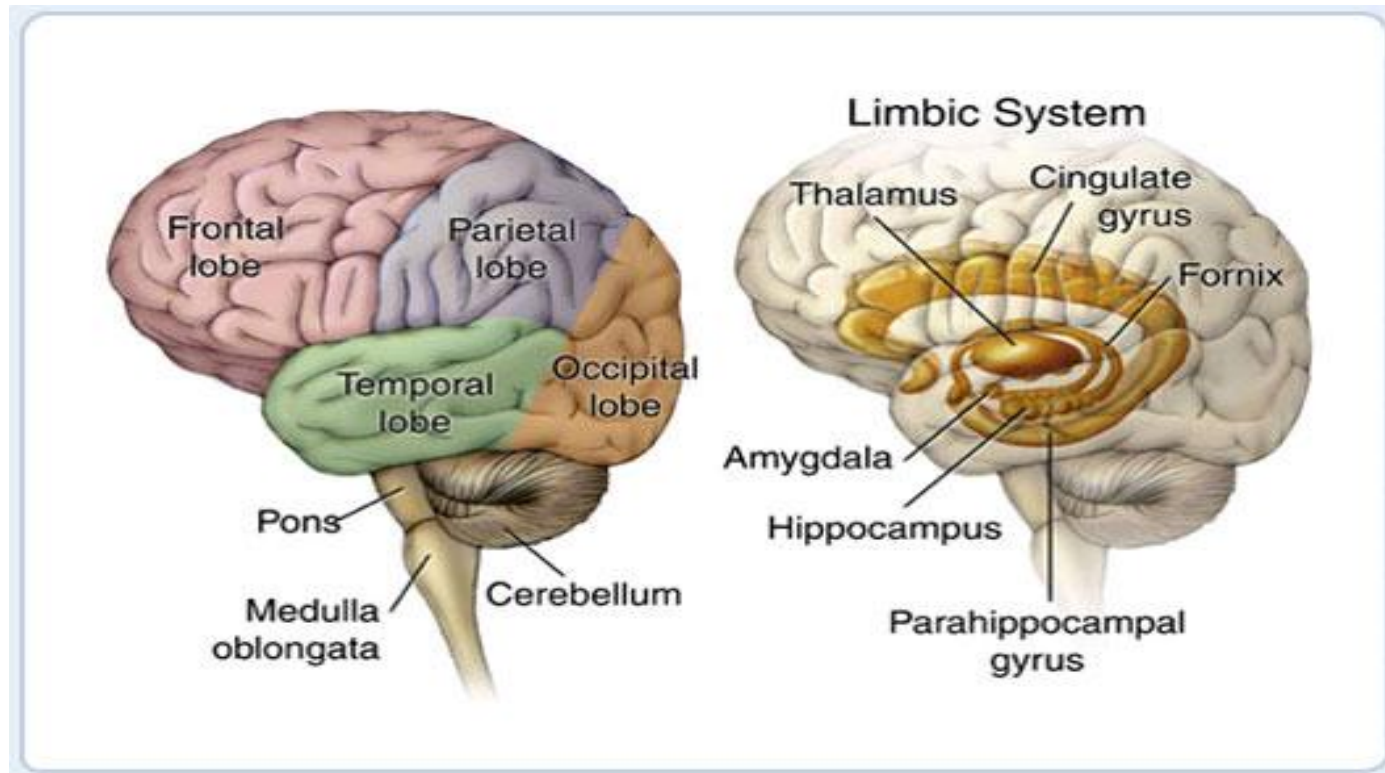
# Allostasis

- ▶ Ability of a system to **maintain stability through change.**
- ▶ Happens in environments of extreme & chronic over-stimulation
  - SUD – intoxication/withdrawal cycle, violence
  - PTSD – War, Rape with re-experiencing cycle
- ▶ Allostatic Load– ‘cost’ to the system for adapting.
- ▶ Long-standing to permanent alterations

# Allostatic deficits in titrating the level of arousal

- ▶ **For both SUD and PTSD – Dysregulation in the HPA Axis, Norepinephrine (NE) and Corticotrophin Releasing Factor (CRF) levels.**
  - Increased NE – ‘resting agitation’ of SUD/PTSD
- ▶ **Increase in CRF levels in both SUD & PTSD**
  - Increased fear response in the Amygdala
    - For SUD patients, increased reward of PTSD avoidance
    - For PTSD patients, increased rewarding properties of drugs of abuse – increased risk of SUD

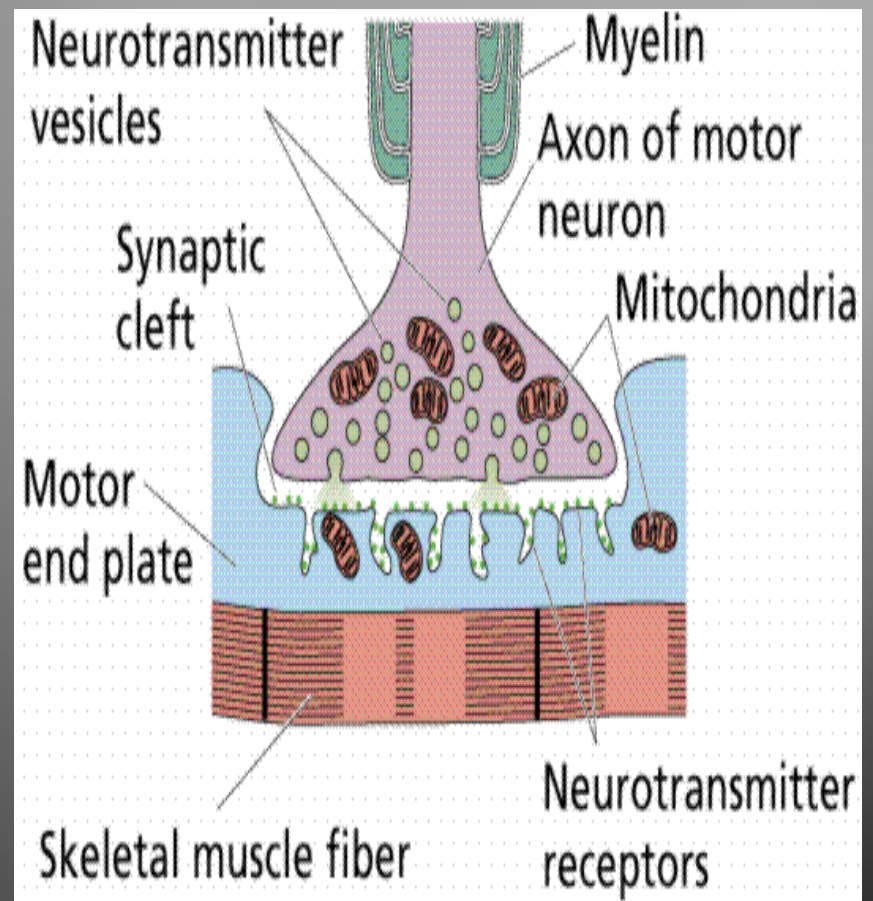
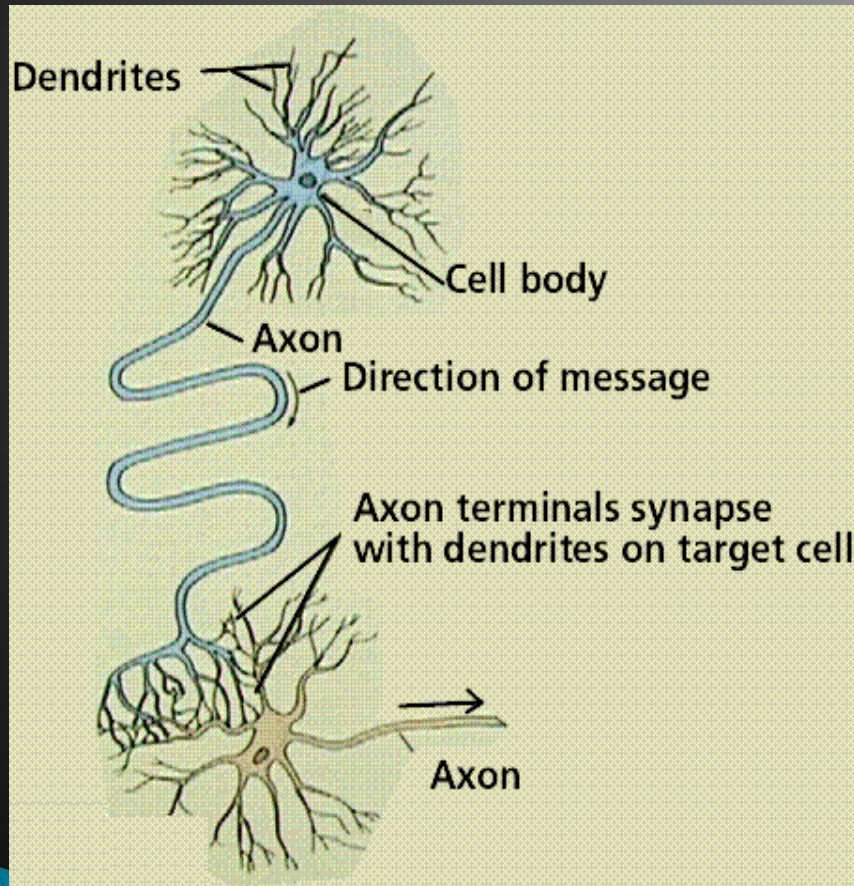
# Limbic System



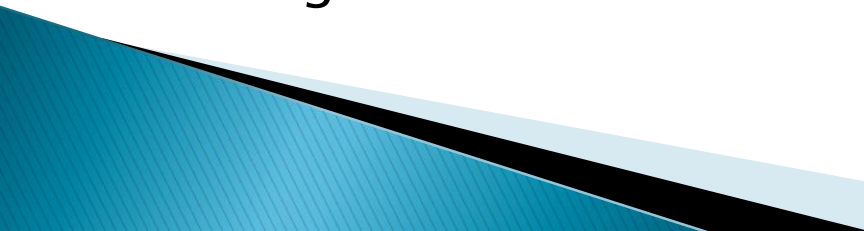
# Limbic System 'survival' goals

- ▶ Moves us towards reward
  - Food/water/shelter/sex
- ▶ Moves us away from Risk
  - Danger cues are quickly selected
- ▶ **Attachment System**
  - We share a similar limbic system with dogs/cats

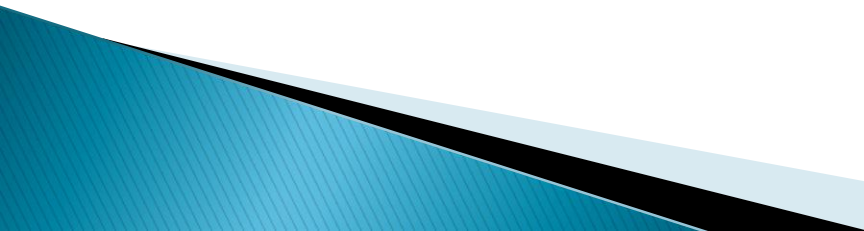
# Neuronal Transmission



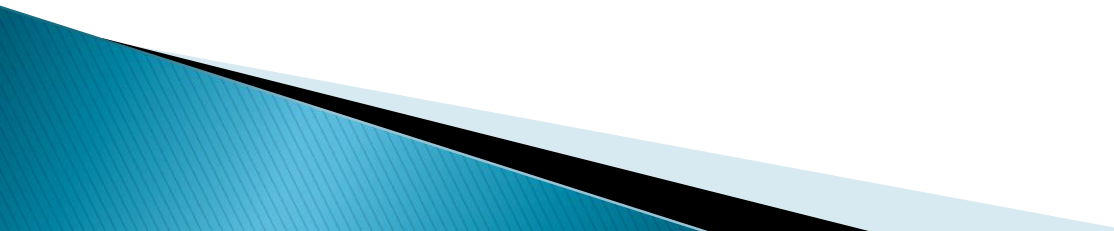
# How SUD/PTSD hijacks the Limbic Survival System

- ▶ Dopamine is a prevalent neurotransmitter in the Limbic System.
  - ▶ SUD drugs of abuse drastically increase Dopamine neurotransmission.
  - ▶ PTSD traumatic events, re-experiencing and hyper-arousal symptoms increase Dopamine neurotransmission.
    - Hebb's Theorem – nerves that fire together, wire together.
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# SUD cue-induced 'mis-wiring' of Limbic Risk/Reward circuits

- ▶ Drug-using behaviors over-wired compared to usual rewarding behaviors – partner, child, family, work, hobby activities.
  - ▶ Patient under-values and fails to behaviorally respond to the dangers of SUD cues
  - ▶ **SUD Tx** – increase/practice functional behavior
  - ▶ Relapse Prevention – **increase avoidance** of cues
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# PTSD cue-induced 'mis-wiring' of Limbic Risk/Reward circuits

- ▶ Trauma cues over-wires avoidant behaviors
  - ▶ Lose normal risk assessment of environmental cues
  - ▶ PTSD Tx – Exposure work – re-wire behaviors to **decrease avoidance of cues**
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# Alterations in Attachments

Terms of Endearment for Drugs/ETOH  
Detachment for SUD  
Detachment or Hyper-attachment for PTSD

# SUD/PTSD – Complex neurobiologic disorder

HPA–altered Distress Tolerance  
Limbic mis–directed behaviors  
Limbic Attachment difficulties

# Dichotomous approaches add to these problems.

Thinking, Treatment, Training



# Dichotomous Thinking

- **Maladaptive cognitive habit.**
  - Extreme, mutually inconsistent & exclusive evaluations
    - Black/White, All/None thinking
  - Cognitively generates extreme emotional reactions/treatment responses
    - Adds to SUD/PTSD distress

# Patient's Dichotomous Barriers for SUD/PTSD tx

- ▶ PTSD as a rationalization against SUD tx
  - I've got an SUD **because** of my PTSD.
    - Just treat my PTSD and I'll stop using!
- ▶ SUD as an avoidance focus against PTSD tx
  - "I don't have PTSD/my PTSD is too painful"
    - So **just** treat my SUD and leave me alone – please!

# Therapist Dichotomous Barriers to SUD/PTSD tx.

- ▶ Dichotomous Thinking about SUD/PTSD pts.
    - PTSD – sympathetic victim schema
    - SUD – unsympathetic repulsive schema
  - ▶ Leads to Dichotomous treatment planning
    - SUD symptoms are normalized because he is ‘just’ self-medicating.
    - PTSD symptoms are ignored because he is ‘just’ and addict.
- Zaslav 1994

# Systemic Dichotomous Barriers

- ▶ **Dichotomous Treatment Settings**
  - Separate/Parallel SUD tx & PTSD tx
  - Sequential – SUD tx first, PTSD tx second
- ▶ **Training of clinicians in either SUD tx or PTSD tx but not both.**
  - Fear of PTSD treatment for SUD clinicians
  - Avoidance of SUD treatment for PTSD clinicians

# How to move past the Dichotomies



# Integrated SUD/PTSD Treatment teams

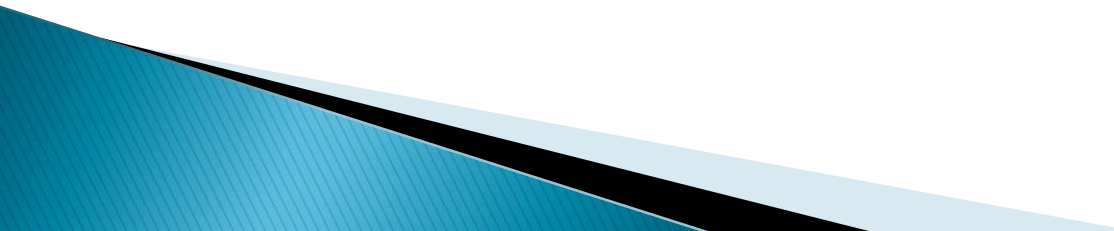
Treating both disorders concurrently  
with the same providers

# ‘Modest’ Evidence for Earlier PTSD tx to reduce SUD relapse risk

- Looked @ temporal course of improvement in PTSD symptoms and Alcohol Dependence symptoms. N=353 w
  - Improvement in PTSD symptoms improved SUD symptoms
  - Improvement in SUD symptoms did not improve PTSD symptoms .
    - These results supports the ‘self-medication’ hypothesis.

Hien et. al. Am J Psych 2010

# Dialectic SUD/PTSD Thinking

- ▶ Look for the fundamental interrelatedness of the SUD/PTSD symptoms and problems.
  - ▶ Stay focused on **functional clinical change and a flexible process of alliance building** rather than programmatic or diagnostic content and structure.
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# Dichotomous vs. Dialectic Tx

## ▶ Structure:

- Program rules/regs
- Abstinence-based SUD
- SUD as exclusion factor for PTSD tx.

## ▶ Content:

- SUD tx separated from PTSD tx
- Separate 'specialized' clinicians

## ▶ Change:

- MI – 'Meet them where they are at' – engage with life goals
- Cross-trained in SUD & PTSD interventions

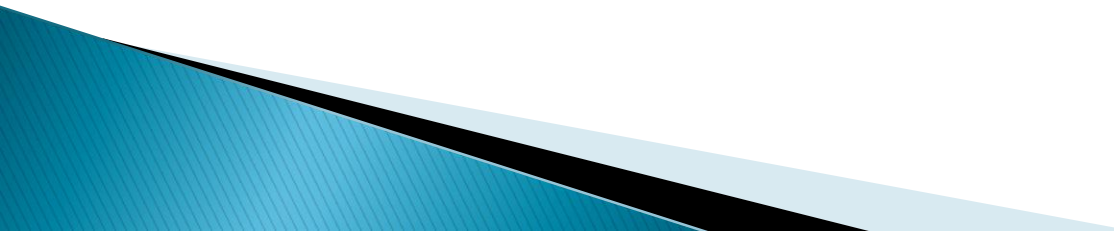
## ▶ Process:

- Therapeutic alliance
- Flexibility

Lower risk, less distress

Higher risk, more distress

# A few clinical pearls to end

- ▶ **Alliance building first** – abstinence second
  - ▶ **Avoid ‘either/or’** treatment planning.
  - ▶ **Compassion** goes much farther than confrontation
  - ▶ **Don’t over-promise** ‘our’ drug’s ability to reduce their symptoms more than ‘their’ ETOH/street drugs
  - ▶ **Build a supportive team** to help with emotional toll and common negative counter-transference reactions.
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# Matches these suggestions for SUD/PTSD patients

- Knowledge of PTSD and SUD tx approaches
- Nonconfrontational & respectful style
  - ‘Parental stance’ , extensive processing of Counter-transference
  - Strongly expressed empathy
- Flexible approach allowing patients to process multiple traumatic events at a ‘slower, stop & go’ pace
- An explicit, extensive written set of safety parameters to address impulsive bx and relapse prevention during PTSD tx.
- Know methods to overcome non-functional resistance to exposure work.
  - Back et.al (2001) and Najavitis et.al (2008)

**Thank You**

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