Trauma and substance use

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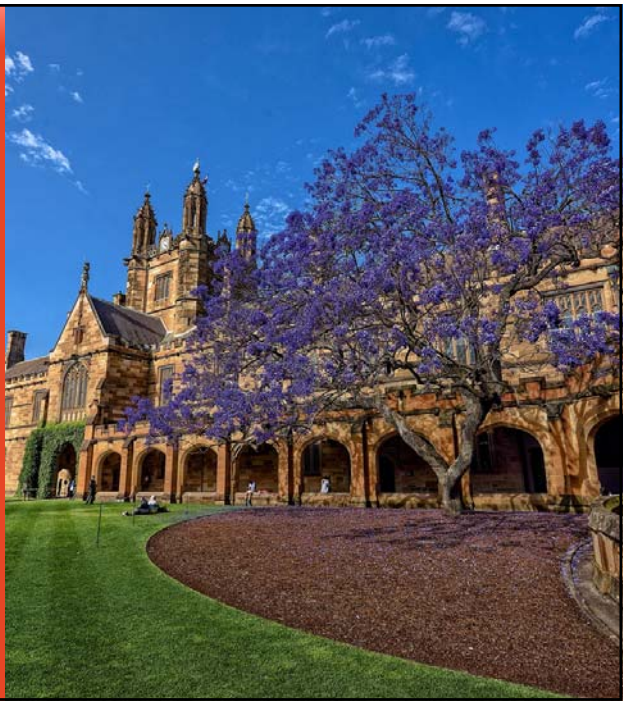

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Trauma & substance use

- The nature of trauma (including post-traumatic stress disorder) and its effects
- The link between trauma and the use of alcohol and other drugs (incl. methamphetamine)
- Approaches to managing and treating trauma symptoms

2

The nature of trauma and PTSD

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What is trauma exposure?

- An <u>event</u> where a person is exposed to:
  - death, threatened death
  - actual or threatened serious injury
  - actual or threatened sexual violence

– The event may be <u>experienced via</u>:
  - direct exposure
  - witnessing, in person
  - indirectly (i.e., learning that a close relative or close friend was exposed to trauma)
  - repeated or extreme indirect exposure to aversive details of events (usually in the course of professional duties)

– May be prolonged or one-off event

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®).

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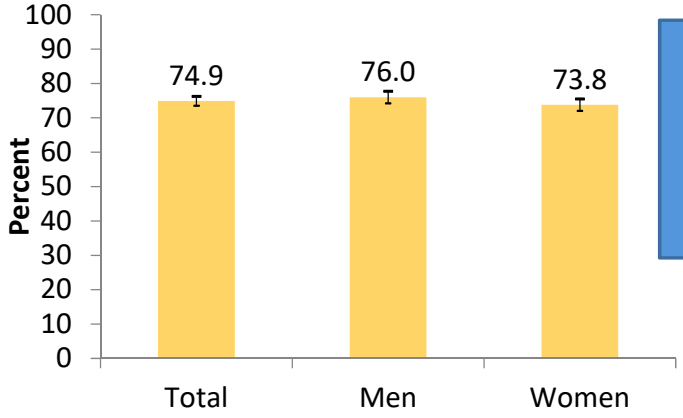
How common is trauma exposure?

n = 11,994,136



75% experience trauma before <16 years of age

67% multiple trauma

Mills, K. L., McFarlane, A. C., Slade, T., Creamer, M., Silove, D., Teesson, M., & Bryant, R. (2011). Assessing the prevalence of trauma exposure in epidemiological surveys. Australian & New Zealand Journal of Psychiatry, 45(5), 407-415.

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How common is trauma exposure?

Men

1. Witnessing serious injury/death (37%)
2. Unexpected death of a loved one (33%)
3. Life-threatening car accident (17%)
4. Mugged, held up, or threatened with a weapon (17%)
5. Life-threatening illness (12%)

Women

1. Unexpected death of a loved one (35%)
2. Witnessing serious injury/death (17%)
3. Sexual assault (15%)
4. Witnessing physical violence in the home as a child (12%)
5. Life-threatening illness (11%)

Mills, K. L., McFarlane, A. C., Slade, T., Creamer, M., Silove, D., Teesson, M., & Bryant, R. (2011). Assessing the prevalence of trauma exposure in epidemiological surveys. Australian & New Zealand Journal of Psychiatry, 45(5), 407-415.

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Consequences of trauma exposure

- Traumatic events are often defining, life-changing moments, regardless of whether a person goes on to develop PTSD or any other trauma-related disorder.
- Whether it be a one-off event or more prolonged, trauma can shape or redefine a person's views about:
  - themselves (e.g. I am weak, bad, worthless)
  - the world around them (e.g. the world is not safe)
  - how they relate to it (e.g. people cannot be trusted)

Mills, KL (2015). The importance of providing trauma-informed care in alcohol and other drug services. Drug and Alcohol Review, 34(3), 231-233.

Mills KL et al. (2012). Integrated Exposure-Based Therapy for Co-occurring Posttraumatic Stress Disorder and Substance Dependence: A Randomized Controlled Trial. JAMA; 308(7): 690-699.

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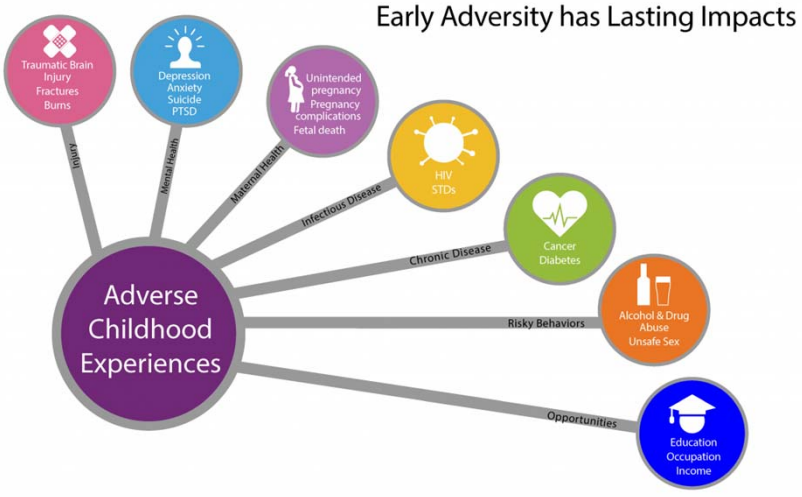
Consequences of trauma exposure

- The earlier the trauma, the greater the risk for these problems
- Those exposed to multiple traumas are at increased risk for cumulative impairment



https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html

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Consequences of trauma exposure

Canada:
Child abuse
↓
all DSM-IV disorders
(Afifi et al., 2014)

USA:
Child physical abuse
↓
PTSD, bipolar, ADHD
(Sugaya et al., 2010)

UK:
Child sexual abuse
↓
PTSD, GAD, eating disorders
(Chou et al., 2012)

WMH Surveys:
Child adversity
↓
elevated risk of all DSM-IV disorders, consistent across country groups
(Kessler et al., 2010)

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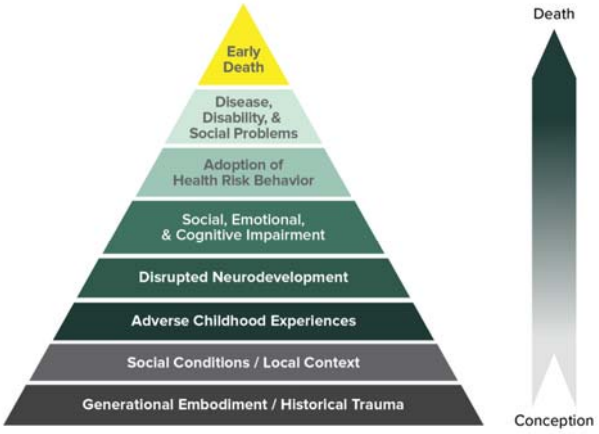
US Adverse Childhood Experiences (ACEs) Study

- ACEs associated with:
  - increased rates of alcohol abuse and illicit drug use,
  - earlier age of onset of illicit drug use,
  - poorer mental health and attempted suicide
- Risk of occurrence and severity of each outcome increased with the number of adverse events experienced (e.g., for each additional event experienced, the odds of developing an illicit drug problem increase by 30- 40%)



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html

Dube SR, Anda RF, Felitti VJ, et al. (2002) Adverse childhood experiences and personal alcohol abuse as an adult. *Addictive Behaviors* 27: 713-725.
Dube SR, Felitti VJ, Dong M, et al. (2003) Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: t adverse childhood experiences study. *Pediatrics* 111: 564-572.
Dube SR, Miller JW, Brown DW, et al. (2006) Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence. *Journal of Adolescent Health* 38(4): 444.e1-10.

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2007 Australian National Survey of Mental Health and Wellbeing

- 1/3 of adults who reported exposure to childhood trauma developed an AOD use disorder (predominantly alcohol and cannabis)
- 3x that of adults who had never experienced trauma (13%)
- 1.3x that of people who had only experienced trauma in adulthood (23%)

Barrett et al. (2015) Substance use and mental health consequences of childhood trauma: An epidemiological investigation. Drug and Alcohol Dependence 146: e217-e218

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What is PTSD?

- The most common psychiatric disorder to occur after a traumatic event
  - **Intrusion/re-experiencing:** intrusive memories, nightmares, flashbacks, physiologic reactivity when exposed to reminders (increased HR, sweating, shaking)
  - **Avoidance:** trauma-related thoughts/feelings, people/places/activities that serve as reminders
  - **Negative alterations in cognitions and mood:** negative thoughts about self and world, self blame, decreased interest in activities and decreased positive affect
  - **Alterations in arousal and reactivity:** irritability/aggression, hypervigilance, exaggerated startle response, difficulty concentrating or sleeping

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®).

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Complex PTSD

- High levels of comorbidity (depression, anxiety, borderline personality traits)
- Complex PTSD = PTSD +
  1. difficulties associated with affect regulation
  2. persistent negative beliefs about oneself
  3. disturbances in interpersonal relationships

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Who develops PTSD?

- Most people do not…

Table 3. *Projected lifetime risk of DSM-IV post-traumatic stress disorder (PTSD) and age at selected age-of-onset percentiles*

	Projected lifetime risk at age 85 years		Age at selected age-of-onset percentiles (years)							
	%	S.E.	5	10	25	50	75	90	95	99
Males	6.2	0.7	6	7	15	24	41	62	69	70
Females	12.9	1.0	4	7	15	26	42	57	72	76
Total	9.7	0.6	5	7	15	26	42	60	70	76

S.E., Standard error.

Chapman et al. (2012). Remission from post-traumatic stress disorder in the general population. Psychological Medicine, 42, 1695-1703.

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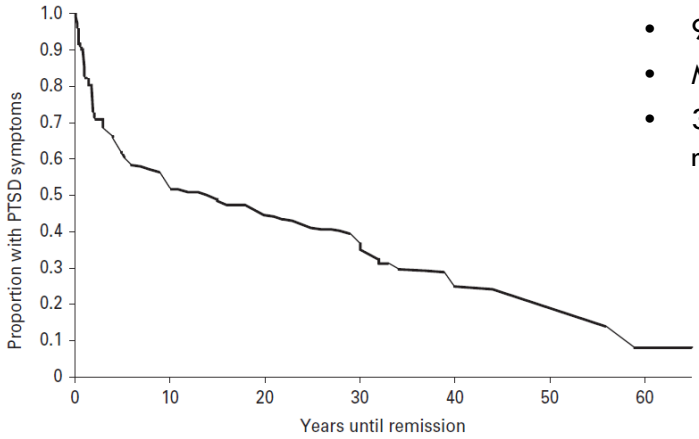
Chronicity



- 92% remission rate
- Median time to remission 14 years
- 37% continue to have symptoms for more than 30 years

Fig. 1. Survival curve indicating years after onset until remission from post-traumatic stress disorder (PTSD) in the population.

Chapman et al. (2012). Remission from post-traumatic stress disorder in the general population. Psychological Medicine, 42, 1695-1703.

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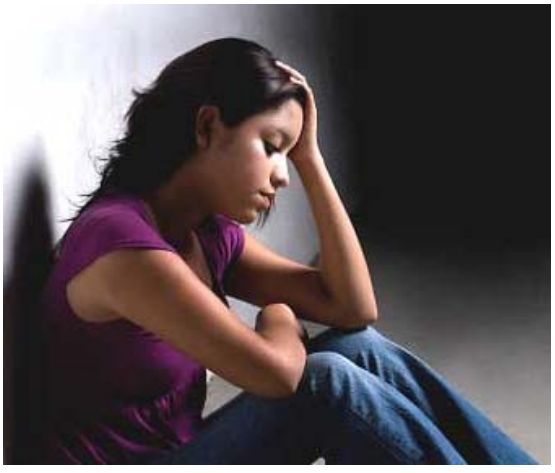
Pre-trauma risk factors



- Previous trauma history
- Personal or family history of psychiatric disorders
- Female sex
- Low social support

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Peri-traumatic risk factors

- Level of distress/threat during the trauma
- Peri-traumatic dissociation
- Violent intent/interpersonal

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Post-trauma risk factors

- Social support
- Symptom severity from 1-2 weeks post-trauma
- Acute dissociative symptoms
- Negative interpretations/rumination about the trauma and its effects
- Ongoing physical complications
- Avoidance *

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The link between trauma, PTSD and substance use

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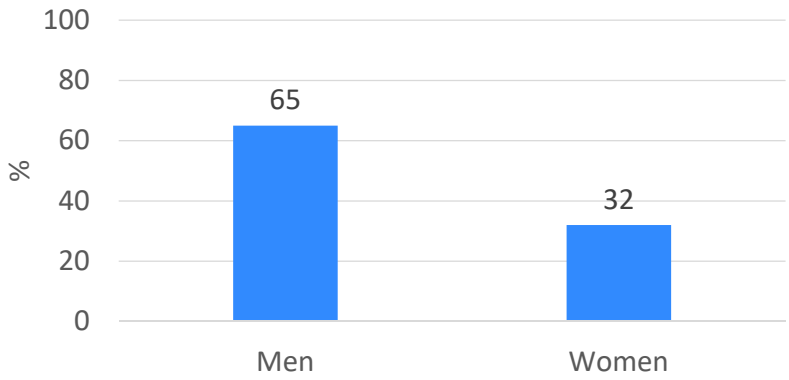
Population estimates: SUD among people with PTSD



Chapman et al. (2012). Remission from post-traumatic stress disorder in the general population. Psychological Medicine, 42, 1695-1703.

Marel et al. (2019) Conditional probabilities of substance use disorders and associated risk factors: Progression from first use to use disorder on alcohol, cannabis, stimulants, sedatives and opioids. Drug and Alcohol Dependence. 194: 136-142

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Population estimates: Order of onset

Table 2. *Co-morbid disorders among those with lifetime post-traumatic stress disorder (PTSD) (n=664)*

	Males						Females					
	PTSD primary		PTSD same year		PTSD secondary		PTSD primary		PTSD same year		PTSD secondary	
	%	S.E.	%	S.E.	%	S.E.	%	S.E.	%	S.E.	%	S.E.
Any affective disorder	45.8	7.6	21.0	6.3	33.2	6.9	40.9	4.5	25.5	3.0	33.6	3.7
Any anxiety disorder	35.4	7.3	8.6	3.6	56.1	7.1	32.6	4.2	19.4	3.4	48.0	4.2
Any substance use disorder	63.6	7.0	4.4	2.0	32.0	6.4	52.0	4.9	11.1	2.9	37.0	4.8
Any mental disorder	41.6	6.6	10.7	3.8	47.7	5.9	33.4	3.4	15.3	2.1	51.2	3.3

S.E., Standard error.

Chapman et al. (2012). Remission from post-traumatic stress disorder in the general population. Psychological Medicine, 42, 1695-1703.

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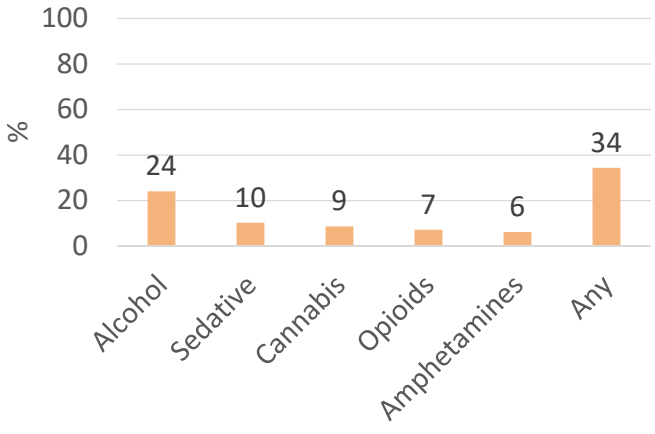
Population estimates: SUD among people with PTSD



Substance	OR (95%CI)
Alcohol	5.2 (3.5 – 7.7)
Cannabis	4.0 (2.2 – 7.2)
Sedative	24.1 (12.9 – 44.8)
Opioid	23.5 (10.5 – 52.8)
Amphetamine	17.1 (7.2 – 40.4)
Any	6.5 (4.6 – 9.4)

Mills et al. (2006). Trauma, post traumatic stress disorder and substance use disorders: Findings from the Australian National Survey of Mental Health and Well being. American Journal of Psychiatry, 163: 651-658.

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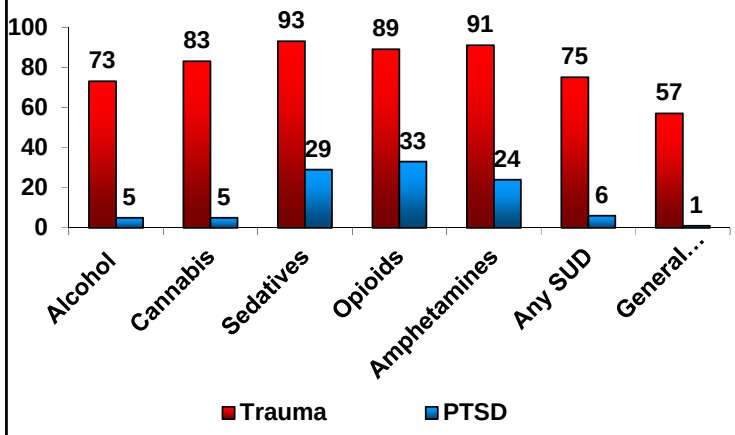
Population estimates: Trauma & PTSD among people with SUD



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Mills et al. (2006). Trauma, post traumatic stress disorder and substance use disorders: Findings from the Australian National Survey of Mental Health and Well being. American Journal of Psychiatry, 163: 651-658.

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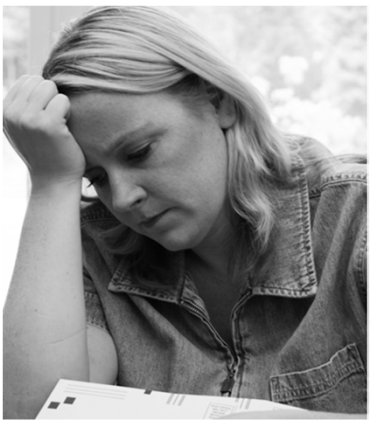
Trauma exposure among clients of AOD services

In Australia, >80% of entrants to treatment report having experienced a traumatic event in their lifetime



Dore et al. Posttraumatic stress disorder, depression and suicidality in inpatients with substance use disorders. Drug Alcohol Rev 2012;31:294–302.
Mills et al. Posttraumatic stress disorder among people with heroin dependence in the Australian treatment outcome study (ATOS): prevalence and correlates. Drug Alcohol Depend 2005;77:243–9.

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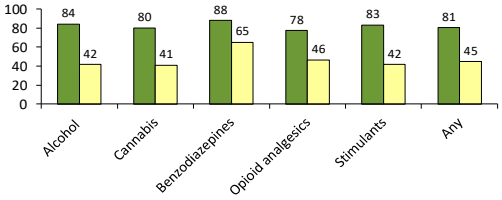
Trauma exposure among clients of AOD services

- Most commonly:
  - witnessing serious injury or death,
  - threatened with a weapon, held captive or kidnapped
  - physical or sexual assault
- The vast majority have experienced multiple traumas



- **Up to two-thirds** of AOD clients have also been found to suffer from PTSD.
- High rates of childhood trauma

Dore et al. Posttraumatic stress disorder, depression and suicidality in inpatients with substance use disorders. Drug Alcohol Rev 2012;31:294–302.
Mills et al. Posttraumatic stress disorder among people with heroin dependence in the Australian treatment outcome study (ATOS): prevalence and correlates. Drug Alcohol Depend 2005;77:243–9.
Kingston et al. A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia. Drug Alcohol Rev. 2017; 36, 527-539.

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Why do SUD+PTSD co-occur?

- Theories to explain the relationship:
  - **Self-medication hypothesis**
    - Self-medication of PTSD symptoms plays a significant role in the development and maintenance of AOD use disorders.
    - The onset of trauma exposure and the development of PTSD symptoms predates the onset of an AOD use disorders in at least half of cases.

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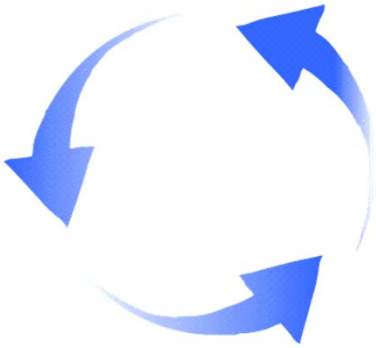
Why do SUD+PTSD co-occur?

- Theories to explain the relationship:
  - Self-medication hypothesis
  - High-risk hypothesis
  - Susceptibility hypothesis
  - Common factors hypothesis



Regardless, once have both disorders each serves to maintain/exacerbate the other

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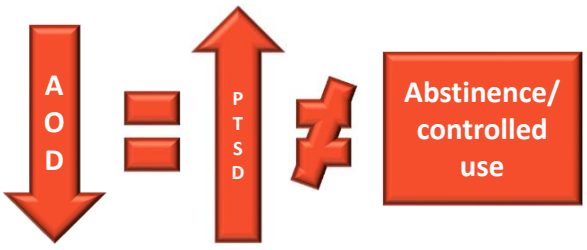
Trauma, PTSD, and AOD use are integrally related

- Improvements in PTSD lead to improvements in substance use but reciprocal relationship not observed - PTSD symptoms do not remit following improvements in substance use.
- On the contrary, PTSD symptoms may worsen in the absence of substance use, making it difficult for patients to sustain abstinence and increasing their risk of relapse to AOD use
- Highlights the centrality of PTSD improvement in the treatment of SUD+PTSD clients.



Back et al. Cocaine dependence and PTSD: A pilot study of symptom interplay and treatment preferences. Addict Behav 2006;31:351–4.
Hien et al. Do treatment improvements in PTSD severity affect substance use outcomes? A secondary analysis from a randomized clinical trial in NIDA's clinical trials network. Am J Psychiatry 2010;167:95–101.
Read et al. Substance use and PTSD: symptom interplay and effects on outcome. Addict Behav 2004;29:1665–72.
Myrick & Brady. Current review of the comorbidity of affective, anxiety and substance use disorders. Curr Opin Psychiatry 2003;16:261–70.
Sharkansky et al. Substance abuse patients with PTSD: identifying specific triggers of substance use and their associations with PTSD symptoms. Psychol Addict Behav 1999;13:89–97.
Dansky et al Untreated symptoms of PTSD among cocaine-dependent individuals. Changes over time. J Subst Abuse Treat 1998;15:499–504.

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Harms associated with PTSD+SUD

Poorer physical health
Poorer psychological health
Poorer psychosocial functioning

↓

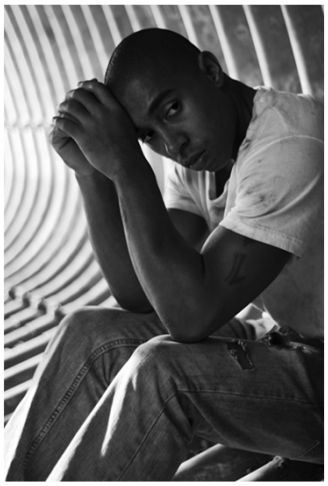
More severe clinical profile

↓

Poorer treatment outcomes

↙ ↓ ↘

Physical health | Mental health | Psychosocial outcomes



Mills et al. (2005). Post traumatic stress disorder among people with heroin dependence in the Australian Treatment Outcome Study (ATOS): Prevalence and correlates. Drug and Alcohol Dependence; 77(3): 243-249.
Mills et al. (2007). The impact of PTSD on treatment outcomes for heroin dependence. Addiction, 102: 447-454.

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Approaches to managing and treating trauma + substance use

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Trauma-informed approaches

- **Trauma Informed Care** - a service level approach that assumes clients have a trauma history and is sensitive and responsive to their needs.
- **Trauma Informed Practice** - the provision of psychosocial treatment of trauma related symptoms.

Metro North Mental Health – Alcohol and Drug Service (2019). Model of Care: Trauma Informed Care and Practice for Alcohol and Drug Treatment. Available at: https://qheps.health.qld.gov.au/__data/assets/pdf_file/0031/2427682/model-trauma-care.pdf

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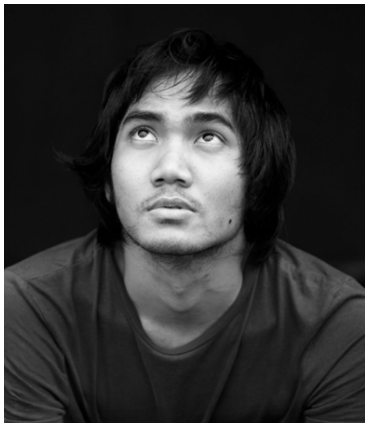
Trauma-informed care

Trauma-informed care is a service delivery approach whereby programs:

- recognise the high rates of exposure to trauma in the patient populations they serve
- provide a safe environment and services that accommodate the needs of patients presenting with a history of significant trauma

It is about understanding the potential impact of trauma on AOD treatment so as to "create treatment environments that are more healing and less retraumatising"



Killeen et al. (2015). Implementation of integrated therapies for comorbid post-traumatic stress disorder and substance use disorders in community substance abuse treatment programs. Drug and Alcohol Review, 34(3), 234-241.

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Trauma-informed care

At a minimum, all members of the AOD workforce should:

- ✓ have an awareness of the extent of trauma exposure among their clientele
- ✓ understand the consequences of trauma exposure and its potential to impact on a recovery
- ✓ be able to recognise the signs and symptoms of PTSD and other trauma-related disorders
- ✓ integrate that knowledge into their practice

Mills (2015). The importance of providing trauma-informed care in alcohol and other drug services. Drug and Alcohol Review, 34(3), 231-33.
Mills & Teesson (2019). Trauma-informed care in the context of alcohol and other drug use disorders. In Benjamin R, Haliburn J, King S. Humanising Mental Health Care In Australia: A Guide to Trauma Informed Approaches. Routledge

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Useful resources

- *Mills & Teesson (2019). Trauma-informed care in the context of alcohol and other drug use disorders. In Benjamin R, Haliburn J, King S. Humanising Mental Health Care In Australia: A Guide to Trauma Informed Approaches. Routledge. Available from katherine.mills@sydney.edu.au*
- *Metro North Mental Health – Alcohol and Drug Service (2019). Model of Care: Trauma Informed Care and Practice for Alcohol and Drug Treatment. Available at: https://qheps.health.qld.gov.au/__data/assets/pdf_file/0031/2427682/model-trauma-care.pdf*
- *Insight webinar: Dr Melissa Connell https://insight.qld.edu.au/training/trauma-informed-care-in-aod-services- from-principles-to-practice/detail*
- *NSW Mental Health Coordinating Council (MHCC) Trauma-informed Care and Practice Organisational Toolkit (TICPOT) + other associated resources (2018). Available at: https://www.mhcc.org.au/resource/ticpot-stage-1-2-3/*
- *Marsh, A., Towers, T., & O'Toole, S. (2012). Trauma-informed treatment guide for working with women with alcohol and other drug issues. Perth, Western Australia: Improving Services for Women with Drug and Alcohol and Mental Health Issues and their Children Project.*
- *Blueknot foundation: https://www.blueknot.org.au/Workers-Practitioners/For-Health-Professionals/Resources-for-Health-Professionals/Trauma-Informed-Care-and-practice*
- *US SAMHSA: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf*

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Psychoeducation

CONTENTS:

Funded by the Australian Government Department of Health and Ageing.

Available at: https://www.sydney.edu.au/content/dam/corporate/documents/matilda-centre/resources/booklets/trauma-and-substance-use.pdf

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Trauma-informed practice

- Some reluctance to address PTSD among AOD clients – too vulnerable, need to address AOD use first, or abstinence is necessary before PTSD diagnosis and management

· Clients prefer this
· More efficient

Sequential Model

SUD treated first → PTSD treated later

Parallel Model

SUD treated by Clinician 1

PTSD treated by Clinician 2

Integrated Model

SUD and PTSD treated at ***same time*** by ***same clinician***

- Ongoing AOD use may impede therapy, but it is not necessary to achieve abstinence before the commencement of PTSD treatment – improvements can be obtained even with continued AOD use

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Evidence-based integrated psychotherapies

- Existing approaches have been divided into two types:
  1. Present-focused therapies (e.g., Seeking Safety www.seekingsafety.org/)
  2. Past-focused therapies
- A recent Cochrane review concluded
  - there is little evidence to support present-focused therapies
  - individual **past-focused therapies** delivered with AOD treatment can reduce PTSD severity and AOD use

Roberts et al. (2015) Psychological interventions for posttraumatic stress disorder and comorbid substance use disorder: a systematic review and meta-analysis. Clinical Psychology Review 38: 25-38.

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Past-focused therapies

- Typically delivered individually, and include the use of exposure techniques in which the client is exposed to reminders of the trauma
- Exposure-based treatments have long been considered the 'gold standard' in treating PTSD
- Similar to exposure for phobias, exposure therapy for PTSD involves exposure to the feared object or situation; in this case, traumatic memories
- In-vivo exposure
  - To people, places, situations that have been avoided (that are not dangerous)
  - Common examples are a crowded supermarket, driving in traffic, watching or reading the news
- Imaginal exposure
  - Repeated and prolonged revisiting of the trauma memory, leads to fear extinction
  - Learn to discriminate between past and present
  - Trauma memories are more organised and maladaptive beliefs are addressed

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Past-focused therapies

- Traditionally, exposure therapy for PTSD was considered inappropriate for people with AOD use disorders based on beliefs that the emotions experienced may be overwhelming and could lead to more substance use
- Evidence suggests that this is not the case; exposure therapy does not lead to an exacerbation of AOD use or increase the severity of the AOD use disorder
- On the contrary, exposure therapy has been shown to be protective with regards to relapse among people with alcohol use disorders 6-months post-treatment

Foa et al. (2013). Concurrent naltrexone and prolonged exposure therapy for patients with comorbid alcohol dependence and PTSD: A randomized clinical trial. Journal of the American Medical Association, 310(5), 488-495

Roberts et al. (2016). Psychological therapies for post-traumatic stress disorder and comorbid substance use disorder. Cochrane Database of Systematic Reviews, Issue 4. Art. No.: CD010204

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Exposure-based integrated psychotherapies

- Support for these programs is growing, with an increasing number of studies providing evidence for their safety and efficacy
- Two large RCTs conducted in Australia.

Mills et al. Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: A randomized controlled trial. Journal of the American Medical Association, 2012; 308, 690-699.

Sannibale et al. Randomized controlled trial of cognitive behaviour therapy for comorbid post-traumatic stress disorder and alcohol use disorders. Addiction, 2013; 108, 1397-1410.

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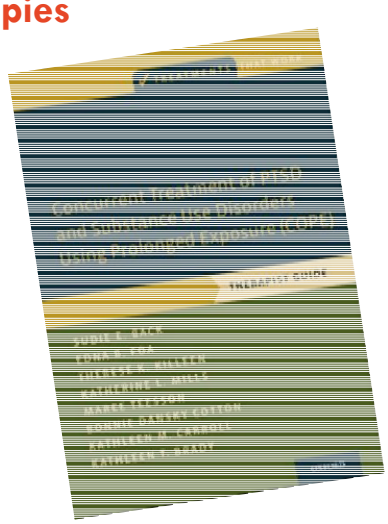
Exposure-based integrated psychotherapies

- Sannibale et al (2013) compared the efficacy of integrated CBT for PTSD and alcohol use with supportive counselling for alcohol use (12 session; n=62). Participants who had received one or more sessions of exposure therapy exhibited a twofold greater rate of clinically significant change in PTSD severity compared to those who receive supportive counselling
- Mills et al (2012) examined the efficacy of an 13 session integrated therapy called **Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE)** among individuals with a range of SUDs (combines CBT for SUD and PTSD, including prolonged exposure), relative to TAU for SUD (n=103).



Mills et al. Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: A randomized controlled trial. Journal of the American Medical Association, 2012; 308, 690-699.
Sannibale et al. Randomized controlled trial of cognitive behaviour therapy for comorbid post-traumatic stress disorder and alcohol use disorders. Addiction, 2013; 108, 1397-1410.

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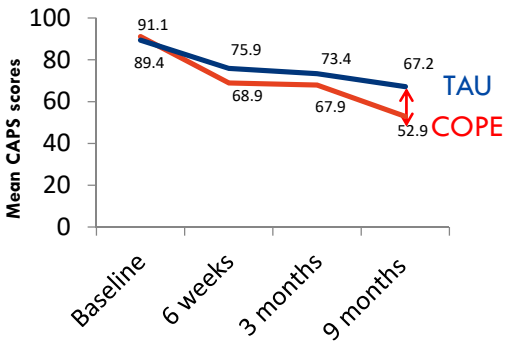
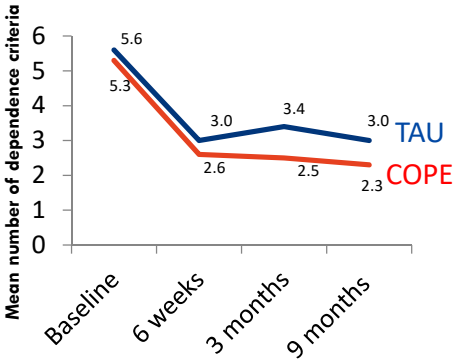
Integrated treatment for PTSD and substance use

PTSD symptom severity



Severity of SUD



Mills KL et al (2012). Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: A randomized controlled trial. JAMA; 308: 690-699.

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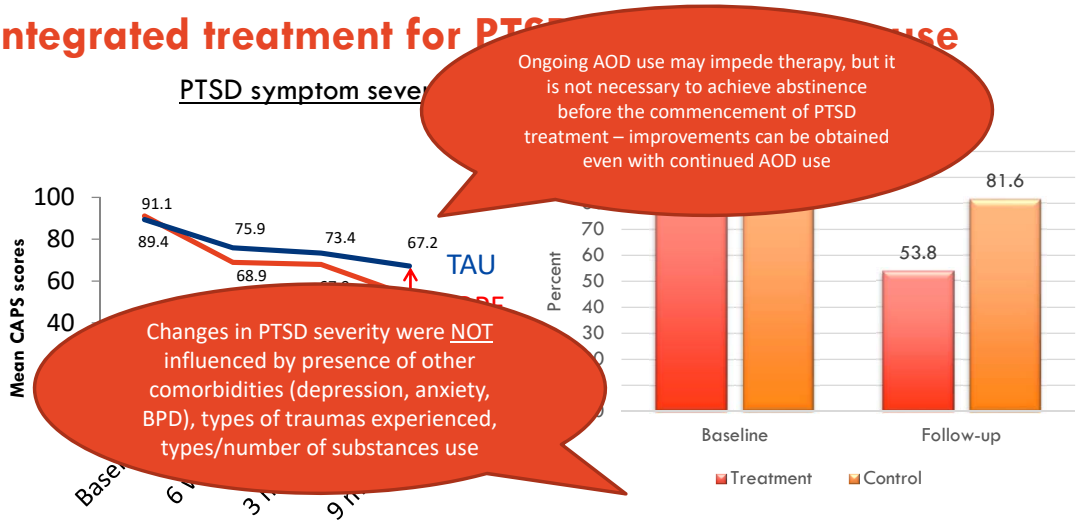
Integrated treatment for PTS[illegible]use



Mills KL et al (2012). Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: A randomized controlled trial. JAMA; 308: 690-699.

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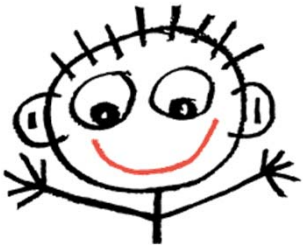
Participant feedback

"The best thing I have done for myself in years.
I hadn't ever spoken about this stuff so it was really helpful"

"It ***helped me realise how much my addiction is linked to the trauma.***
I can now talk about the incident without freaking out"



"No one had ever talked to me about my trauma before.
It was good to put a name to my symptoms"

"The imaginal exposure was the ***hardest part but also the most useful****."*

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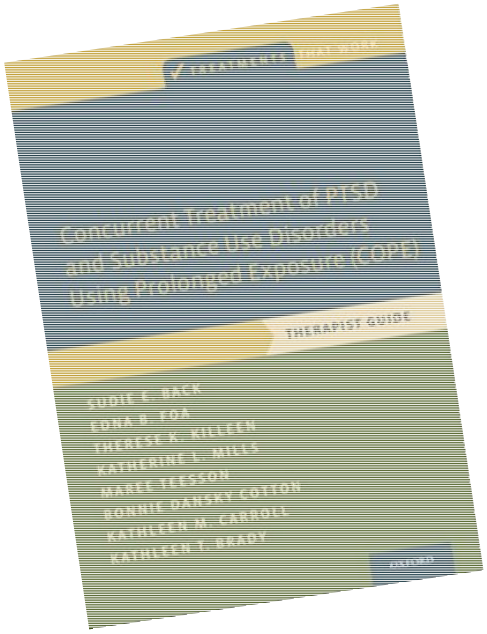

The COPE Treatment manual is published in the Oxford University Press *'Treatments that Work' series* and available online

Back, SE, Foa, EB, Killeen, TK, Mills, KL, Teesson, M, Cotton, BD, . . . Brady, KT, Concurrent treatment of PTSD and substance use disorders using prolonged exposure (COPE): Therapist guide. 2014, New York, NY: Oxford University Press.

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Further research (COPE)

- Persson et al (2017) conducted a pilot study of COPE among 22 women in Sweden. Significant reductions in all efficacy-related outcomes, including PTSD and depression symptom severity, alcohol use, craving, and dependence severity.
- Ruglass et al (2017) compared the efficacy of COPE and Relapse Prevention Therapy (RPT) for substance use relative to an active monitoring control group (n=110). Both groups demonstrated significantly greater reductions in PTSD and SUD compared to active monitoring. Participants with full PTSD (vs subthreshold) demonstrated significantly greater reductions with COPE relative to RPT.
- Back et al (2019) compared the efficacy of COPE to Relapse Prevention among military veterans (n=81). COPE, resulted in significantly greater reductions in PTSD symptom severity, PTSD diagnostic status. Both groups evidenced significant and comparable reductions in SUD severity during treatment. At 6-months follow-up, participants in COPE evidenced significantly fewer drinks per drinking day than participants in RP
- Mills et al (underway) RCT comparing a modified version of the COPE program for adolescents (COPE-A) and young adults (aged 12-25yrs) compared to supportive counselling. Further information: http://www.copea.org.au/

Persson, A., Back, S. E., Killeen, T. K., Brady, K. T., Schwandt, M. L., Heilig, M., & Magnusson, Å. (2017). Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE): A Pilot Study in Alcohol-dependent Women. Journal of addiction medicine, 11(2), 119-125.

Ruglass, L. M., Lopez-Castro, T., Papini, S., Killeen, T., Back, S. E., & Hien, D. A. (2017). Concurrent treatment with prolonged exposure for co-occurring full or subthreshold posttraumatic stress disorder and substance use disorders: A randomized clinical trial. Psychotherapy and psychosomatics, 86(3), 150-161.

Back, S. E., Killeen, T., Badour, C. L., Flanagan, J. C., Allan, N. P., Santa Ana, E., ... & Brady, K. T. (2019). Concurrent treatment of substance use disorders and PTSD using prolonged exposure: a randomized clinical trial in military veterans. Addictive behaviors, 90, 369-377.

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Other trauma-focused therapies

- Coffey et al (2016) compared the efficacy of a modified version of prolonged exposure (mPE), mPE + trauma-focused motivational enhancement session (mPE+MET-PTSD), to a health information-based control condition (HLS) (n=126). All participants received residential substance abuse treatment-as-usual. Both the mPE and mPE+MET-PTSD conditions achieved significantly better PTSD outcome than the control condition. 75.8 % of mPE participants, and 60.0% of the mPE+MET-PTSD participants experienced clinically significant improvement
- Carletto et al (2018) compared integrated EMDR for trauma and SUD + TAU (EMDR+TAU) to TAU for substance use alone (n=40). Significantly greater improvements for EMDR+TAU than TAU in relation to symptoms of PTSD, dissociation and anxiety.
- Markus et al (2015) comparing EMDR for trauma and SUD + TAU (EMDR+TAU) to TAU for substance use alone (target n=100)... Underway
- Tapia et al (2017) conducted a pilot study of schema therapy + EMDR for PTSD and SUD (n=15) found reductions in PTSD symptoms, the number of ealry maladaptive schemas, addiction severity and depressive symptoms.
- Vujanovic et al (2018) pilot RCT to evaluate the feasibility and preliminary efficacy of a novel, CPT+CBT approach for PTSD/SUD (Treatment of Integrated Posttraumatic Stress and Substance Use; TIPSS), as compared to standard CBT for SUD. Both treatment conditions are comprised of 12, 60-minute individual psychotherapy sessions, delivered twice-weekly over six weeks.

Coffey, S. F., Schumacher, J. A., Nosen, E., Littlefield, A. K., Henslee, A. M., Lappen, A., & Stasiewicz, P. R. (2016). Trauma-focused exposure therapy for chronic posttraumatic stress disorder in alcohol and drug dependent patients: A randomized controlled trial. Psychology of Addictive Behaviors, 30(7), 778.
Carletto, S., Oliva, F., Barnato, M., Antonelli, T., Cardia, A., Mazzaferro, P., ... & Pagani, M. (2017). EMDR as Add-on Treatment for Psychiatric and Traumatic Symptoms in Patients with Substance Use Disorder. Frontiers in Psychology, 8, 2333.
Markus, W., de Weert–van Oene, G. H., Becker, E. S., & DeJong, C. A. (2015). A multi-site randomized study to compare the effects of Eye Movement Desensitization and Reprocessing (EMDR) added to TAU versus TAU to reduce craving and drinking behavior in alcohol dependent outpatients: study protocol. BMC psychiatry, 15(1),
Tapia, et al (2017). Treating addiction with schema therapy and EMDR in women with co-occurring SUD and PTSD: A pilot study. Journal of Substance Use, 1-7. 51.
Vujanovic et al (2018). Development of a novel, integrated CBT for co-occurring posttraumatic stress and substance use disorders: A pilot randomized clinical trial. Contemporary clinical trials, 65, 123-129.

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Summary

- Trauma exposure and PTSD + AOD are common and associated with significant harm and poorer treatment outcomes
- BUT... there is hope
- Growing evidence demonstrating the safety and efficacy of trauma-focused treatments
- Participants in these studies did not demonstrate a worsening of symptoms or high rates of relapse; on the contrary, they demonstrated improvements in relation to both AOD use and PTSD outcomes.
- Challenges:
  - How to we build resilience among young people and adaptive coping strategies for adverse events?
  - How do we support people to seek help when needed? How do we intervene early?
  - How do we incorporate evidence based treatments into practice? Trauma informed → trauma focused?

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Thank you

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https://vimeo.com/comorbidity

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