Treatment for PTSD and Substance Use Problems in Veterans

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Goals of workshop

- Define Posttraumatic Stress Disorder (PTSD)
- Review overlap between PTSD and substance use problems
- Describe an integrated treatment for PTSD and substance use problems
- Introduce two evidence-based treatments for PTSD used at the VA
What is Posttraumatic Stress Disorder?
PTSD: Criterion A

Experiencing or witnessing an event that involves actual or threat of death or injury to oneself or to another person

Feeling horrified, terrified, or helpless during the event

Not every stressful experience is traumatic
B. Re-experiencing (At Least 1 Symptom)

- Distressing recollections of the trauma
- Distressing dreams of the event
- Reliving the experience (flashbacks)
- Psychological distress at exposure to trauma reminders (internal or external)
- Physiological reactivity to trauma reminders
  - Heart rate
  - Sweating
  - Shaking
C. Persistent Avoidance (At Least 3 symptoms)

- Efforts to avoid trauma-related thoughts, feelings, or conversations
- Efforts to avoid trauma-related activities or situations
- Inability to recall parts of the trauma
- Diminished interest in activities
- Detachment from others
- Restricted range of affect
- Foreshortened future
D. Increased Arousal  (At Least 2 Symptoms)

- Sleep disturbances
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response
# Prevalence of PTSD

<table>
<thead>
<tr>
<th></th>
<th>Point Prevalence</th>
<th>Lifetime Risk</th>
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<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Among Community Samples</td>
<td>1.2%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Among Veterans</td>
<td></td>
<td></td>
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<tr>
<td>Vietnam</td>
<td></td>
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<td>Gulf War</td>
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<tr>
<td>OEF/OIF</td>
<td>11%</td>
<td>13%</td>
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<tr>
<td>(receiving care in VA 2001 - 2005)</td>
<td></td>
<td></td>
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<tr>
<td>Among combat deployed OEF/OIF</td>
<td></td>
<td></td>
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<tr>
<td>troops</td>
<td></td>
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<tr>
<td>All deployed OEF/OIF troops</td>
<td>2-11.6%</td>
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</table>

Bresslau & Kessler, 2001; Cusack et al, 2004; Norris, Foster, & Weisshaar, 2002; Seal et al, 2007; Smith et al, 2008; Suffoletta-Maierle et al, 2003; Switzer et al, 1999; Tolin & Foa, 2006;
Reexperiencing

Hyper-arousal

Avoidance

Reexperiencing

Symptom Interplay

Irritability
Problems sleeping
Always being on high alert

People, places, conversations, thoughts, situations, etc.

Intrusive thoughts or images
Nightmares
Triggers
Connection between PTSD and substance use problems
PTSD & Substance Use Disorders (SUD)

- Community samples (National Comorbidity Study):
  - Men diagnosed with PTSD:
    - 52% alcohol abuse
    - 35% drug abuse
  - Women diagnosed with PTSD:
    - 28% alcohol abuse
    - 27% drug abuse
  - Substance abuse diagnosis:
    - 40-60% meet criteria for PTSD
PTSD & Substance Use Disorders

• Veteran samples
  ▫ PTSD Diagnosis:
    • 73% meet criteria for substance abuse (NVVRS)
Relationship between PTSD and SUD

• Before the traumatic event:
  ▫ Intoxication increases likelihood of trauma exposure
  ▫ Substance abuse increases susceptibility to developing PTSD

• After the traumatic event:
  ▫ PTSD leads to development of substance abuse (self-medication)
  ▫ Substance use can exacerbate PTSD (prevent habituation)
  ▫ Substance withdrawal symptoms mimic PTSD symptoms
Impact of Dual Diagnoses

- Lower functioning
- More diagnoses
- Worse relationships
- Less employment
- More legal problems
- Poorer treatment response
- More hospital admissions
- Increased suicidality
- More substance use
- Increased risk for future trauma
Treatment for PTSD and substance use problems
Targets for treatment

- Reducing substance use does not lead to lower PTSD symptoms
- Reducing PTSD symptoms appears to be related to lower substance use**

- Clients report higher motivation for PTSD treatment than SUD treatment
Approaches to treatment

• Sequential treatment:
  ▫ Treat substance use first
  ▫ Treat PTSD first

• Concurrent treatment

• Integrated treatment

• People prefer integrated treatment
Approaches to treatment

- Past focused
- Present focused
Stage 1:
Integrated Treatment for PTSD and Substance Use Problems
Background

- Developed by Lisa Najavits in the 1990s
- First integrated PTSD/SUD treatment with published outcomes
Stages of Treatment

• Stage 1: Safety
• Stage 2: Mourning
• Stage 3: Reconnection

*Seeking Safety* is a Stage 1 treatment
Principles of Treatment

- Principle 1: Safety is the first priority
  - Abstinence** from substance use
  - Improve relationships
  - Improve coping skills
  - Reduce suicidality and self-harm
  - Improve emotion regulation
Principles of Treatment

• Principle 2: Integrated treatment of PTSD and substance use
  ▫ Recognize interrelationship between disorders
  ▫ Identify coping skills for both disorders
  ▫ Understand course of both disorders
  ▫ Increase compassion for both diagnoses
Principles of Treatment

- Principle 3: Focus on ideals
  - Address shattered assumptions associated with trauma
  - Loss of ideals with substance use
  - Exs: Honesty, commitment, compassion
Principles of Treatment

• Principle 4: Case Management, Cognitive, Behavioral, and Interpersonal content areas
  ▫ Cognitive: Creating Meaning, Recovery Thinking
  ▫ Behavioral: Taking Care of Yourself, Respecting Your Time; weekly commitment
  ▫ Interpersonal: Healthy Relationships, Setting Boundaries
  ▫ Case Management: Community Resources at check-in and check-out
Principles of Treatment

• Principle 5: Attention to Therapist Processes
  ▫ Building an alliance
  ▫ Compassion for patients
  ▫ Giving patients control
  ▫ Good modeling
  ▫ Getting honest feedback about treatment
    • Check-out: Thoughts about session
Conducting the Treatment

- **Check-in:** (5 minutes)
  - How are you feeling?
  - What good coping have you used?
  - Any substance use or unsafe behavior?
  - Did you complete your commitment?
  - Community resource update?
Conducting the Treatment

**Quotation:** Purpose is to engage patients emotionally and provide a brief point of inspiration that they might remember for the future.

**Examples:**
- “Although the world is full of suffering, it is also full of the overcoming of it.”  Helen Keller
- “You are not responsible for being down, but you are responsible for getting up.”  Jesse Jackson
- “The future depends on what we do in the present.”  Mohandas Gandhi
Conducting the Treatment

- **Review content:**
  - Cognitive: Creating Meaning, Recovery Thinking
  - Behavioral: Taking Care of Yourself, Respecting Your Time
  - Interpersonal: Healthy Relationships, Setting Boundaries
  - Case Management: Community Resources
Conducting the Treatment

• Review content:
  ▫ Role plays
  ▫ Didactics
  ▫ Quizzes
  ▫ Select certain handouts
  ▫ Read aloud parts
  ▫ Summarize/Review key points
Conducting the Treatment

- **Examples of content:**
  - *Taking care of yourself*: Self-care questionnaire
  - *Compassion*: Harsh self-talk vs. compassionate self-talk
  - *Red and Green Flags*: Safety plan
  - *Honesty*: Hypothetical situations about lying to child or residential program
  - *Create meaning*: Meanings that harm and meanings that heal (cognitive restructuring)
Conducting the Treatment

- **Check-out:**
  - Name one thing you got out of today’s session
  - Any problems with the session?
  - What is your new commitment?
  - What community resources will you call?

- **Commitment Sheet:**
  - Examples from substance use topic—
    - Attend AA meeting
    - Identify advantages and disadvantages for substance use
    - Create list of rewards for self that are not substances
Research: RCTs

  - SS had lower PTSD and SUD scores at post-treatment

  - Mixed results. No differences between SS and TAU at post-treatment, but improvement in psychopathology vs. alcohol at follow-up

- Hien et al. (2009): 353 community women in SUD treatment. 12 sessions of Seeking Safety vs. 12 sessions of health education
  - No differences in outcomes except more rapid improvement in SS

- Hien et al. (2004): 107 women in community. 24 sessions of Seeking Safety or Relapse Prevention vs. TAU
  - No difference in treatment outcomes for active treatments and outcomes not maintained
Research: Pilot studies and controlled trials

- **Treatment retention:**
  - Gatz et al (2007); 402 women in community SUD treatment

- **Reduced trauma symptoms and substance use:**
  - Najavits et al. (1998). 17 community women
  - Zlotnick et al. (2003). 17 incarcerated women
  - Desai et al. (2008). 91 homeless female Veterans
  - Norman et al. (2010). 14 OEF/OIF Veterans
  - Young et al. (2004). 99 women in SUD treatment

- **Treatment length:**
  - Ghee et al (2009): 6 sessions not sufficient
Stage 2:

Treatment for Posttraumatic Stress Disorder
What are the leading treatments for PTSD?

  - Cognitive therapy (particularly CPT)
  - Exposure therapy (particularly PE)
  - Stress inoculation training
  - Eye movement desensitization and reprocessing
Conclusion of the 2008 Institute of Medicine Report

- “The committee finds that the evidence is sufficient to conclude the efficacy of exposure therapies in the treatment of PTSD” (Chapter 4, page 97)

Elements of Leading Treatments

• Direct Therapeutic Exposure
  ▫ Emphasis on repetitive verbalization of traumatic experience
  ▫ Use of real-world in vivo exposure assignments

• Cognitive Therapy
  ▫ Emphasis on systematic cognitive restructuring of negative trauma-related beliefs

• Both CPT and PE are protocol-driven and require a strong therapeutic alliance
What is Prolonged Exposure?
What is Prolonged Exposure?

- PE is a trauma-focused therapy that helps the patient reengage with the trauma memory and situations they have been avoiding.
- PE involves an average of 10 (range 8-15) 90-minute weekly individual sessions with a trained clinician.
Prolonged Exposure Consists of:

1. Education about PTSD and common reactions to trauma (25 minutes)
2. Breathing retraining (10 minutes in session 1)
3. Imaginal exposure to the trauma memory
   ▫ Patient is instructed to describe the event in detail (30-45 minutes during sessions 3-10); hotspots
   ▫ Processing 15-20 min
4. Daily in vivo exposure to safe situations, activities, and other avoided trauma-related reminders
5. Review progress and plan for the future (session 10)

Foa, Hembree, & Rothbaum (2007)
Weekly Homework Review

- Starts each session
- Includes ratings of pre-, post-, and peak SUDS for both imaginal and in vivo exposures

Homework assignments include:
- Listening to the audiotape of the session once over the next week and to the imaginal tape daily
- Doing 2-3 in vivo exercises daily
- Practicing calm breathing
Rationale for PE

Three main factors prolong post-trauma dysfunction:

1. Avoidance of trauma-related situations
2. Avoidance of trauma-related thoughts and images
3. Presence of unhelpful or distorted cognitions:
   • The world is extremely dangerous
   • I am extremely incompetent
How Does Exposure Therapy Work?

- Imaginal exposure enhances the emotional processing of the trauma memories and helps the patient gain a realistic perspective on the trauma.
- In vivo exposure reduces trauma-related distress and enables the patient to realize that the avoided situations are not dangerous.
- Both help to modify dysfunctional, negative cognitions underlying PTSD:
  - The world is extremely dangerous
  - I am incompetent
What is CPT?

Cognitive Processing Therapy
Veteran/Military Version:

THERAPIST’S MANUAL

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Veteran/Military Version:

CPT PATIENT WORKBOOK

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What is Cognitive Processing Therapy?

- CPT is a trauma-focused therapy that views PTSD as a disorder of non-recovery.
- It is based on social cognitive theory that focuses on how the trauma is construed.
- Therapy examines the content of cognitions and the impact that these have on emotional response and behavior.
- CPT is a 12-session treatment with 60-minute weekly sessions. It can be applied in a group or individually.

Resick, Monson, & Chard, 2008
Making Sense of a Traumatic Experience

- **Assimilation**: altering incoming information to match prior beliefs
  - “I learned as a child that people cannot be trusted and this event confirmed that belief.”

- **Accommodation**: altering beliefs enough to incorporate the new information
  - “I always thought that people could be trusted, but now I know that I can’t trust anyone.”

- **Over-accommodation**: altering one’s beliefs about oneself and the world to feel more in control
  - “If I had only been watching the road more carefully, I could have prevented the IED from exploding. This is my fault.”

Resick, Monson, & Chard, 2008
Domains of Functioning

5 areas of focus in CPT:

- Safety
- Trust
- Power/Control
- Esteem
- Intimacy

Resick, Monson, & Chard, 2008
# Challenging Beliefs Worksheet

Resick, Monson, & Chard, 2008

<table>
<thead>
<tr>
<th>A. Situation</th>
<th>B. Thought/Stuck Point</th>
<th>D. Challenging Thoughts</th>
<th>E. Problematic Patterns</th>
<th>F. Alternative Thought(s)</th>
</tr>
</thead>
</table>
| I led my company into an ambush, and many of my men were killed. | I should have prevented it – it is my fault that people were killed. – 100% | Evidence For? People were killed. Evidence Against? There was no way to know that there was going to be an ambush—that’s the nature of an ambush. To think I should have known it was coming is to ignore the fact that it was an ambush. | Jumping to conclusions:  
Exaggerating or minimizing:  
Disregarding important aspects: I haven’t been paying attention to the fact that it was an ambush. There was no way I could have known.  
Habit or fact?  
Interpretations not accurate?  
All or none? No one else would have led their company into an ambush. | What else can I say instead of Column B? How else can I interpret the event instead of Column B?  
Rate belief in alternative thought(s) from 0-100% |

<table>
<thead>
<tr>
<th>C. Emotion(s)</th>
<th>G. Re-rate Old Thought/Stuck Point</th>
<th>H. Emotion(s)</th>
</tr>
</thead>
</table>
| Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%  
Guilt – 100%  
Helpless – 100%  
Anxious – 75% | Re-rate how much you now believe the thought/stuck point in Column B from 0-100%  
10% | Now what do you feel? 0-100%  
Guilt – 40%  
Helpless – 80%  
Anxious – 40% |
Acknowledgements

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Questions?

Thank you