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PTSD 101 Course

Transcript for: Managing PTSD and Co-Occurring Substance Use Disorders

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Welcome to the PTSD 101 course on managing PTSD and co-occurring substance use disorders.

I'm Dan Kivlahan, Acting National Mental Health Program Director for Addictive Disorders in the Office of Mental Health Services in the Veterans Health Administration.

And I'm Dr. Kaysen. I'm an Associate Professor at the Department of Psychiatry and Behavioral Sciences at the University of Washington, and I'll be back later to chat with you all a little bit about how to deal with substance use disorders when you're working actively with somebody with PTSD and doing cognitive behavior therapy.

I have no conflicts of interest to disclose. I have previous research funding from the National Institute on Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, VA Health Services Research and Development, and the VA Quality Enhancement Research Initiative.

We have four overall objectives today. First, is to review evidence on co-occurrence of substance use disorders in PTSD. Next, we'll identify the key recommendations for integrated treatment of SUD and PTSD from the VA/DoD 2010 PTSD Clinical Practice Guidelines. Next, we'll identify measures and methods for treatment monitoring related to PTSD and substance use disorders. And finally, with the help of Dr. Kaysen, we'll illustrate ways of addressing substance abuse in PTSD treatment. Dr. Debra Kaysen will be helping to discuss this topic and demonstrating how she assesses and treats SUD within PTSD treatment and, specifically, the Cognitive Processing Therapy protocol.

So, our first objective is to review the evidence on co-occurrence of substance use disorders in PTSD.

If we look at the general community prevalence of the co-occurrence of these disorders, lifetime prevalence of PTSD among individuals seeking treatment for substance use disorders has been reported as high as 50 percent, but these rates vary tremendously based on the particular context in which the data are collected. In the population with PTSD, lifetime prevalence of co-morbid substance use disorders was 22% in the national co-morbidity survey, a number of years ago. In the studies that have looked prospectively at information on co-occurrence, there's evidence of an increased risk for the onset of nicotine dependence, a topic I'll return to several times as we go along, as well as an increased risk for drug abuse or dependence in persons with PTSD.

This next slide has five major boxes. The largest is PTSD, nearly as large as the central box for substance use disorders, but I've also included boxes for major depressive disorder, schizophrenia, and bipolar, and you can see that there's overlap among these groups. What may come as a surprise is that the overlap between substance use disorders in PTSD is actually slightly lower than is the overlap for SUD in the other major mental health conditions. Nevertheless, it's still 21% of those with a PTSD diagnosis during that fiscal year also had a diagnosis of substance use disorders.

Next, we take a look at the number of Veterans in VHA care who have PTSD diagnosis, and substance use disorders. Displayed here are the data from fiscal year 2002, to last fiscal year, FY11. You can see that the percentage of patients who have both disorders, among those who have any SUD, has increased from 14 percent in FY02 to nearly 25 percent last fiscal year. In the interim, if you looked in the FY08 figure, that number, the absolute number, has jumped from 80,000 Veterans with both conditions in FY08 to nearly 120,000, a 50 percent increase, by fiscal year 11. So, the trend is clearly accelerating.

But, there's often a focus, especially in the media, but also in our clinical settings, on returning Veterans from Iraq and Afghanistan. This next table presents cumulative information since the start of data collection back in FY02 through the end of the fourth quarter of last fiscal year. The first data column shows the total number of Veterans, returning Veterans, who got any of these mental health diagnoses during that entire period of time, and the second data column reflects the percentage change in that number since the previous fiscal year. So, for PTSD, the most prevalent of the diagnosed conditions, over 200,000 returning Veterans had the diagnosis sometime during that period. And, that percentage increased 24 percent between the end of FY10 and the end of FY11.

As you look down the list, you can see highlighted five substance use disorder diagnoses, the most prevalent of them being tobacco use disorder, with nearly 125,000 of those Veterans having some documented diagnosis of tobacco use disorder during that period. In that instance, I can't tell you the change since the previous fiscal year because they weren't reporting the information in that detail at that time. But, the next most frequent substance use disorder is alcohol abuse, nearly 50,000 Veterans, followed by alcohol dependence, 44,000, and in that instance, we can see that the number increased by 31 percent compared to the prior fiscal year, followed by non-alcohol abuse of drugs. So, that is disorders involving drugs other than alcohol or tobacco. And, finally, drug dependence, which was over 22,000 in that cumulative period, but increased by 37 percent from FY10 to the end of FY11. So, you can see that there's a general trend in increasing at least the identification of these disorders in this group of returning Veterans.

Now, let's look at the trends in substance use disorder diagnoses for Veterans who have both PTSD and substance use disorders. Again, in this figure on the vertical axis, it shows the absolute number of Veterans, and this number has increased most greatly among those in the top line of the figure. It shows those with an alcohol use disorder diagnosis only.

The middle line represents those who have both an alcohol and other drug use disorder diagnosis, and the bottom line reflects those who have a drug use disorder in the absence of some alcohol use disorder. So, the trend is up, but most sharply up among those with the alcohol use disorder, and our colleagues in the Department of Defense will definitely emphasize that that's the substance about which they're most concerned. In the VA, we have the opportunity to help Veterans who've also identified other substance use disorders in addition to alcohol.

But, there are some differences by the drug for Veterans who have the co-occurring disorders. This figure, again, the vertical axis shows the absolute number of Veterans, and the horizontal axis shows this change over the fiscal year since FY02. For a number of years, the most prevalent of the specific drug use disorder diagnosis was cocaine use.

In FY09, cannabis use disorders exceeded cocaine use disorders for the first time, and you can see that that number now amounts to over 25,000 Veterans in fiscal year 11 is continuing to increase sharply. There's also an increase in the second to the lowest line in the figure that reflects those with opioid use disorder diagnoses, and opioid disorder diagnoses don't distinguish the source of that drug; could be heroin from the streets. Increasingly, it could be prescription opioids. The bottom line in the figure reflects those with amphetamine use disorders, and we generally see this concentrated in selected geographic areas, and even in FY11, that number was lower than 5,000 Veterans during the fiscal year.

So, this figure reflects just the subgroup of Veterans with substance use disorders who also had PTSD diagnoses. And, of those, with the co-occurring conditions, back in FY02, nearly half received some specialty treatment for the substance use disorders. You can see that that percentage that got specialty care fluctuated around the 40% level over the fiscal years and continues to be right around 40% in FY11.

Now, that contrasts with roughly a third of all Veterans who have the substance use diagnosis, who wind up receiving some specialty care. So, it's more likely that a Veteran, who has PTSD along with the substance use disorder, will get some specialty care, than is the case for other Veterans with SUD, yet, still the majority do not have any contact with SUD specialty care in the course of a given fiscal year.

Well, that provides some overview about the epidemiology of the disorder, or at least as we see it primarily in VA. It's more difficult to see those trends outside of the VA system, but let's shift to our second objective, which is to identify some of the key recommendations for integrated treatment of SUD and PTSD that are documented in the VA/DoD Clinical Practice Guideline that was revised in 2010.

The guideline, as are other VA/DoD guidelines, is available at the website, www.healthquality.va.gov. And you can see from the screen shot in this figure that there are a number of different modules or components of the Guideline, some of which address adjustment reactions, as well as those that are focused on Posttraumatic Stress Disorder. There's also some effort to address the issues that are distinctive in the primary care setting as well as the specialty mental health setting. And, unlike the original Guideline addressing PTSD and acute stress reaction, this guideline had a specific section to look at the co-occurrence of SUD and PTSD.

Well, I want to provide you with some caveats on guidelines. It's important to recognize that they're an aide in decision making, but the strength of the evidence is variable, and that's definitely true when it comes to treatment of these co-occurring conditions. And, the guideline development process for the scientific data are lacking recommendations relied on the clinical experience of the working group. Bottom line about guidelines is that, they do not prevent providers from using their own clinical expertise in the care of an individual Veteran as that person presents for care. Judgment is still an essential part of the process.

Let's review the major recommendations that come from the VA/DoD PTSD Guideline for addressing co-occurring substance use disorders. First, is that all patients diagnosed with PTSD are at high risk for other SUD, including nicotine dependence. Nicotine dependence can't be overemphasized as the major preventable cause in morbidity and mortality among our Veterans.

Second recommendation is to offer treatment when nicotine dependence is identified, and we have some evidence-based approaches to doing that. That evidence is so strong that you can see next to recommendation two, there's an A in brackets, and that reflects a strong recommendation that clinicians provide the intervention to eligible patients.

The third recommendation indicates that patients often are not adequately familiar with the connection between substance use disorders and PTSD, and how recovery from one can affect one's success at managing the other, or how exacerbation of one can really result in deterioration in the other. Sometimes

we can rely on patient's prior treatment experience, and that can help inform it, but they're still likely to have preferences about how they start, and what they can do with, the relationship between those two conditions. And then, we have no single intervention that we can have high confidence is going to address the cormorbidity. We don't have evidence of a single treatment of choice.
And, you can see there that the recommendation has in brackets an I, which reflects the fact that there's insufficient evidence to recommend for or against routinely providing the intervention. So, often in this respect, the best starting point is the starting point that the Veteran is willing to accept and to work on as you monitor the response to that initial starting point.

Fourth overall recommendation is the important principle to treat the disorders concurrently. This is consistent with the VA Guideline for substance use disorders, including concurrent pharmacotherapy. So, addiction-focused pharmacotherapy should be discussed, considered, available, and offered, when it's indicated, for all patients with alcohol dependence or opioid dependence. And, once initiated, this pharmacotherapy needs to be monitored for adherence and for the treatment response. How does the Veteran experience it? What do they identify as some of the benefits and, potentially, some of the harms?

Fifth recommendation is that it's important to provide multiple services in the most accessible setting that will promote engagement, and coordination of care, for both the substance use disorder and the PTSD. The principle of one-stop shopping, of integrating that care in a way that makes it most likely that the Veteran will initiate and maintain involvement with that process so that they can get the maximum benefits for their recovery.

Sixth, in order to determine whether things are working, it's not enough to say this is a practice that has evidence behind it, and it should work for the Veteran. It's critical to determine whether it is working, and that requires reassessing the response to treatment periodically and systematically, and that should involve standardized, and validated, self-report instruments, laboratory tests, for example, for drug use, and that indicators of treatment response need to include use, craving, side effects of medication, emerging symptoms that may not have been evident when the process began, etc. So, it really needs to be a multi-faceted process of reassessing along the way.

Finally, there's insufficient evidence to this point to recommend for or against, any specific psycho-social approach to addressing PTSD that's cormorbid with the substance use disorder. We don't have the same strong recommendation that exists for evidence-based care of PTSD, where we do have some well-established front-line interventions. So, there's more of an effort here to get things started and to re-evaluate, so that we can adjust to get the maximum benefit.

So, let's return to the recommendations and elaborate on them a little bit. So, I mentioned that comprehensive assessment is important. That needs to include nicotine dependence, but it's not enough just to identify the nicotine dependence. It's important to offer some effective strategies to help Veterans address that and to establish some long-term abstinence from nicotine dependence.

Fortunately, there's an extremely well-validated approach to doing this and integrating smoking cessation efforts within PTSD treatment. This is a result of a recently-completed VA cooperative study across ten sites that was led by Dr. McFall and Dr. Saxon. You can see the reference for the major publication off of that trial in the Journal of AMA, published in December of 2010. There is a PTSD 101 course that elaborates on this effective intervention, and I encourage you to visit that and find ways to effectively integrate that into your routine practice.

Also, I had mentioned the recommendation about education regarding the relationship between PTSD and use of substances.

And, the importance of treating the concurrent substance use disorder with the VA consistent with the VA Clinical Practice Guidelines for SUD addressing specific aspects of pharmacotherapy.

For those colleagues who work within the VA system, you're familiar with a handbook that establishes the basic package of services required to be available in all VA medical centers and clinics. And, consistent with the Guideline, it emphasizes the importance of pharmacotherapy for treatment with opioid agonist and having that available to patients who are diagnosed with opioid dependence. The most recognized agonist treatments are buprenorphine and methadone. There's also an antagonist treatment for opioid dependence, and that's used with naltrexone, another medication available in our VA formulary.

This treatment can be delivered in either or both of the following settings. Many of you are familiar with treatment and opioid treatment programs, often referred to as methadone maintenance clinics, where they're highly-regulated approaches to helping Veterans establish their recovery from opioid dependence; very careful monitoring and medications, and it's quite a systematic approach, but there are many restrictions on how those can be delivered.

A more recent alternative, that provides much greater flexibility, is office-based buprenorphine treatment. This is limited to physicians who have a special waiver, based on some training and expertise, to prescribe this medication, but it allows medication to be offered in general substance use disorders clinics, in the PTSD clinic, even in primary care. Concurrently, 132 of our medical centers make this available as well as 109 of the community-based outpatient clinics. So, there's growing access to this very evidence-based medication that is extremely effective in helping Veterans with opioid dependence, whether or not they have PTSD.

This next table shows how our efforts to make this available have increased over the last few years. Three rows on the table, information for fiscal year 09, fiscal year 10, and last fiscal year, indicates the number of Veterans who were treated with either methadone or buprenorphine and compares that to the number who had a diagnosis of opioid dependence during that time. The most striking is the fact that, just in the past two fiscal years, the number of Veterans with opioid dependence and PTSD treated was up almost 60 percent. Now, that slightly exceeded the rate of increase in the diagnose prevalence of opioid dependence among those with PTSD, but that, too, is up substantially, 40 percent over the last couple of fiscal years.

So that, during FY11, as you can see out in the far right-hand column, the bottom of that column, approximately 32 percent of Veterans with the co-occurring conditions received one of these evidence-based medications during the fiscal year, and that's showing some improvement, but we still need to assure that that's an opportunity that's available for any Veteran who has opioid dependence, particularly those who have the co-occurring PTSD.

So, we've talked about pharmacotherapy for opioid dependence. Let's turn, now, to pharmacotherapy for alcohol dependence, and, as you recall, that's the more prevalent of the substance use disorders among Veterans with PTSD.

Now, this is a figure that shows the trends over time for the four FDA approved medications for treatment of alcohol use disorders. This is not specific to those with alcohol use disorder and PTSD, but the trends are reflective of the overall pattern. So, the first group of data reflects changes in Acamprosate, the next is for oral Naltrexone. The one that has the least amount of data, and the least current use, is injectable Naltrexone. Next is Disulfiram, or antibuse, and then, finally, you can see the total column that reflects any initiation of any of these FDA approved medications for alcohol dependence.

So, since FY04, that has more than doubled in the absolute number of Veterans receiving any of these medications, and if you recall from one of our earlier slides, that still reflects fewer than ten percent of all

the Veterans who have substance use disorder. So, our penetration overall has still got a lot of room to improve, and it's very important to get this treatment option on the agenda early in the process of making a treatment plan, but also revisiting it as time goes on, since oftentimes the Veteran will say, “I don't have any interest in using that option at this point.” Sometimes, after they've tried it their way, they may be more willing to consider it as an effort if things don't go so well.

Well, let's turn to the issue of making services accessible across settings and how we can most effectively promote engagement of the Veteran into treatment. Oftentimes, when they have mixed feelings about getting started in the first place, and how we can coordinate care so that both the PTSD and the substance use disorder are addressed.

Again, referring back to the seminal VA directive on required services, there's an important emphasis that, when PTSD, or other mental health conditions, co-occur with a substance use disorder, I mentioned before pharmacotherapy needs to be made available as do psycho-social interventions for the conditions, and there needs to be appropriate coordination of that care. So, that's an expectation across all of our medical centers.

So, this next figure is from national data, 2008 national survey on drug use and health, reflecting the total American population. The bottom of the figure, you can see that the large circle represents the over 20 million individuals who need but do not receive treatment for illicit drug or alcohol use disorders. So, all these people meet criteria for the condition and should have some treatment opportunity. The bulk of the people in that large circle, 95 percent, didn't get treatment and didn't feel they needed treatment.

So, the Veteran who comes into you and says, “I don't need your help for this. I can handle it on my own,” is very similar to the bulk of the other people in the population reflected in this figure. There are two smaller segments. One is those who felt they needed treatment and did not make an effort. Our responsibility is to assure that it's easier for them to access that care. And the smallest segment, the one percent, are those who felt they needed treatment, did make an effort, but somehow didn't get connected, and clearly, we have to reduce the barriers so that they get the care they need. But this is a treatment engagement challenge that we need to continue to understand and try to address.

Given that a lot of individuals who have an apparent need for treatment don't seek it, what are some of the perceived barriers? These data come from a study by Dave Osland and colleagues at the VISN-4 MIRECC in Philadelphia and VISN-2 Center of Excellence colleagues in Syracuse. They identified nearly 200 primary care patients with alcohol dependence, who were assessed through the behavioral health lab. And, they inquired about the reasons that these Veterans declined referral for treatment of their alcohol dependence. Most of them indicated that they didn't perceive a need for treatment, but there were a number, 37%, who had treatment in the past, had a negative experience, and they concluded that treatment wasn't going to work for them.

Over a third indicated that they had worries about stigma. Some other bad consequences that might be involved with seeking treatment. For nearly a quarter, based on logistical concerns, scheduling, transportation, and so forth. The least common were some family-related concerns. Nevertheless, even though all these Veterans had declined treatment in the specialty clinic, 44 percent indicated that they would be willing to initiate naltrexone, an evidence-based medication for alcohol dependence, if they could get that in the primary care clinic. So, the lesson out of this is that, if you make options available, regardless of the setting, there often is greater willingness on the part of Veterans to consider those. And, Dr. Osland will be presenting the results of that trial in the coming months, and we'll all be able to learn a great deal from that.

So, we just summarized a number of the barriers to engaging Veterans in treatment for their SUD. One of the ways that the VA has initiated to try and address those barriers is by hiring a designated SUD/PTSD

specialist at each of our major medical centers. Their effort is to try and change the culture towards integrated care for the conditions regardless of the setting where the Veterans present.

This slide, pie chart, shows that these specialists provide their services in a number of different settings. They do some by group, some by individual. You can see the variation at the national level. We can assure you that at the local level, there's considerable variability in how they identify the best way to add some value to the existing services that are being offered. So, flexibility is a hallmark of the services that these specialists for the direct care they provide. They also provide a range of services with consultation, with training, and with other efforts to try and improve that culture of care.

We've been able to inquire of the specialists about the services that they're most typically delivering. This was a sample of convenience of nearly half of those who are working in this role, in various medical centers, and we asked them which of the identified treatments for substance use disorders they were most often integrating into their services. And, you can see here, that far and away the most commonly used intervention is Seeking Safety, which is an evidence-based, manual-guided approach to integrating care for substance use disorders and PTSD.

They're also using cognitive behavioral therapy and motivational interviewing and less so with systematic motivational enhancement therapy, 12-step facilitation, or some other interventions. So, we continue to try and learn more about how they're working this into the services that they provide, but you can see that Seeking Safety is a highly relied on intervention, and for many of them, it's identified as an effective engagement strategy to try and help Veterans appreciate the connection between the SUD and the PTSD. In some instances, it seems to be sufficient to help stabilize Veterans. In other instances, it helps prepare Veterans to engage in the more focused interventions for treating the PTSD symptoms, and that would be the Prolonged Exposure or the Cognitive Processing Therapy that Dr. Kaysen will talk about shortly.

Let's turn to the third objective. Try to emphasize the importance of ongoing reassessment, systematic measurement for monitoring response to treatment for the co-occurring conditions.

It's important that this be done periodically and systematically, and the selection of methods is important, and that it is insufficient to just ask whether somebody's been using since there are other factors that can help identify how well they're doing with stabilizing the recovery and also, some of the factors that may put them at risk for relapse.

This is another theme that's also reflected in the VA handbook on uniform mental health services: the importance of monitoring a condition in an ongoing matter and using that information to adjust the care as appropriate.

This is often referred to as measurement-based care, and there are some challenges involved with implementing this in a consistent way. It's important to see how changes are occurring with symptoms, but symptoms aren't the only story in recovery. There are other recovery-oriented dimensions like employment, social function, and quality of life, and we also need to understand the patient's experience of care; that's beyond satisfaction. That also goes to whether it's recovery oriented effort to really do things that are consistent with that model of intervention.

Measurement-based care is a culture change for many patients and providers to really build this into ongoing practice, and we need to find some efficient ways to do this. Ultimately, we expect that that will involve some technological solutions, but we're not there quite yet. We also recognize that Veterans have co-occurring conditions, as we're identifying with PTSD and substance use disorders. So, it's important to track progress in both of those areas and to find out how we can do this across settings of care.

So, for monitoring progress with treatment of addiction, we've identified an approach called the brief addiction monitor, also referred to as the BAM. It has three major categories of items. It asks explicitly about substance use, it identifies some risk factors for relapse, and it also identifies some of the protective factors, some of the indications that things are going better and some strengths to build on.

So, this slide is an example of how the brief addiction monitor items will appear in the mental health assisted software as part of our electronic health record. It's difficult to read, but it's just basically asking about how many days of use, whether it was use of alcohol, heavy use of alcohol, or use of illegal, or street drugs, as well as abuse of any prescription medications.

It's not sufficient to focus entirely on substance use for this group of co-occurring conditions. I just want to remind you that the standard approach to monitoring treatment response for PTSD is the PTSD checklist. This is a 17-item self-report measure, same number of items as the brief addiction monitor. There's a link available to download and learn more about the PTSD checklist, but, again, it's important to build both the PTSD checklist and the brief addiction monitor into ongoing care for this population.

We can turn now to our final objective, which is to illustrate some of the ways of addressing substance use disorders within PTSD treatment.

Remember, the seventh of the specific recommendations from the guideline was that, currently there is insufficient evidence to recommend for, or against, any specific psycho-social approach to addressing PTSD that's cormorbid with the substance use disorder. So, the insufficient evidence is the indication of that I rating on the recommendation.

Within treatment of substance use disorders, this next busy slide tries to make several points about the differences that are available. In the top row, you can see that psycho-social treatments could be first-line treatments, that are at least as effective as other alternatives, or, in some instances, there are adjunctive treatments. They are in addition to other standard care. And, that it makes a difference whether you're talking about a primary alcohol, opioid, stimulant, or cannabis use disorder, the level of evidence is different.

The rows of this table reflect the most widely studied and validated approaches to treatment of substance use disorders, and at this point, we don't have compelling evidence that any of these are either more likely to be effective or less likely to be effective for Veterans who have the co-occurring PTSD. And, we can talk a lot about the level of evidence that's still accumulating for these interventions. I just want you to be aware of the fact that it depends on which drug, in which context, and what type of intervention, is likely to be the best starting point for an individual Veteran.

But, more so than the specific, if you will, brand name therapy that one provides, there are some key principles from the VA/DoD Guideline for treatment of substance use disorders that I want to emphasize. First, is importance of providing both pharmacotherapy and psycho-social treatment options to the Veteran, and sometimes the Veteran is going to decide which of those are acceptable to them, and that may be a conversation that needs to be revisited over time.

Next is that, regardless of which of the particular interventions that I just identified on the previous slide, how you deliver those is at least as important as what you deliver. Fundamental emphasis is on using a motivational interviewing style during encounters with patients, and recognizing that there are common elements of effective interventions that cut across the specific approaches. So, this has to do with emphasizing the therapeutic relationship, being aware of issues related to motivation, improving self-efficacy for change, identifying coping skills that are going to be relevant to that Veteran, and that they need some help to improve, lining things up so that they can get some of the added benefits of recovery,

many of which are delayed beyond the time when somebody starts trying to make this change; sometimes things get worse before they get better.

And, the final theme is one that puts our services in context, is that our goal is really to enhance social support for recovery. It's not to be the only support that's available. So, linking Veterans with peers, with family, with church, with other people who are supportive of their recovery in the community, that's what helps to sustain change for the longest time.

I'd like to switch now to Dr. Kaysen and have her talk some about how she approaches managing substance use disorders in the context of treatment that's really focused on recovery from the PTSD symptoms. Dr. Kaysen's an expert in treatment of the co-occurring disorders and has been a consultant in some of the VA's efforts to roll out Cognitive Processing Therapy for providers working with Veterans with PTSD.

So, if you're doing a PTSD therapy, and you have someone who has co-occurring substance use, abuse or dependence, I think there are a number of ways in which substance use can get in the way of those kinds of therapies. If you go to those models, those theoretical models, you can really think about the role of self-medication. So, the idea is that people are using substance use to avoid trauma-related cues, triggers, emotions, which is exactly the opposite of what you're trying to get people to do if you're doing a therapy like Cognitive Processing Therapy or Prolonged Exposure where we really think that avoidance maintains or keeps those PTSD symptoms going.

The problem is that if you have someone who is substance using over the course of a cognitive behavioral therapy that's focused on PTSD, each time they use the substance, it makes that desire for avoidance stronger. So, it reinforces that avoidance behavior. Both Cognitive Processing Therapy and Prolonged Exposure assume that one of the ways that people get better is that processing of the emotions around the trauma. If the person is using substances every time they feel those emotions, it's going to stop that emotional processing, which is going to potentially make those therapies less effective. If you're doing a therapy like Prolonged Exposure, which uses habituation as a primary mechanism, then substance use is actually going to interfere with that habituation therapy. Theoretically, you would see less habituation, and the person, again, will get less of a good therapy outcome if they're continuing to use substances to self-medicate.

Depending on the substance that somebody's using, different medications or drugs can interfere with retention, with short-term memory. It can interfere with sleep, which also is going to interfere with memory encoding. Again, Prolonged Exposure, Cognitive Processing Therapy, the whole idea with those treatments is you're teaching people skills. If they're using substances, that can get in the way.

And, lastly, all of these therapies, assuming the person's coming in weekly, that they're doing their homework, that they're actively engaged. Somebody who's involved with substances, they may not be coming as regularly. They may be spending a lot time using substances rather than engaging with the therapy. So, it's very important to increase engagement and to contract with the person to either abstain or to reduce use in a way that it's not going to interfere with the treatment.

There are a number of other ways in which substance use can get in the way of doing a trauma-focused cognitive behavioral therapy. Clearly, if somebody is using in ways that are life threatening, in quantities that are concerning, also substance use can interfere with or can increase suicidality. If you've got somebody who's using substances, they may ramp up to becoming suicidal much more quickly. It increases risk of suicidality and homicidality. If you're not assessing the quantities that someone's using, you may not be aware that they're consuming potentially lethal doses of alcohol or drugs. So, it's really important to do a good assessment and potentially to contract around use to reduce risk.

I think one of the biggest concerns for therapists is this fear that the person is going to relapse if you do a trauma focused cognitive behavioral therapy. We know from data that people who use substances relapse. And, they relapse more when they have untreated PTSD. So, this is one of the dilemmas, is if I treat the PTSD, do I, then, reduce the person's risk of relapsing. It's really helpful to have a good assessment about how long a person's been able to stay clean and sober, what their history has been like, of use, to know whether or not this is a good time to begin treatment.

Getting a sense of what the person's triggers around relapse are, I think, are very, very helpful things, in terms of assessment. You can also do some work around coping skills. What does the person have currently for coping? Skills like urge surfing, using the cognitive behavioral therapy skills themselves to reduce triggers to anticipate problems can also be really, really helpful. Having the person avoid cues, for example, can decrease that chance for relapse. I also think having a very upfront conversation with a client about those concerns is helpful. "I really want to treat your PTSD, I hear that's why you're here. But, I'm worried about relapsing. Talk to me about how we're going to keep you safe and clean and sober."

If a person does relapse, or lapse, during the treatment, it's really important to say how bad it is, how much of a concern that is. A lapse isn't necessarily a relapse. A person can go back to using the substances, but get back on track pretty quickly. But again, it's a good place to have a heart to heart conversation with your client, "You know, talk to me about what led to this. What can we do to make sure that that doesn't happen again so that we can continue with the PTSD treatment."

I think one thing to be really aware of is this idea of the abstinence violation effect. Often, when somebody has a lapse, they essentially throw their hands up in the air and say, "Well, there's no point." And, they don't wind up getting back on track. So, that's one of the things to predict for the client and talk about how can we get you back in the direction you want to be moving in.

So, I think one question for therapists is what do I do with substance use if I'm doing a trauma-focused therapy? Dr. Kivlahan talked earlier about the idea of motivational interviewing. This is an incredibly valuable skill set for therapists to have, if they're going to work with co-occurring disorders. It's really helpful at the beginning to negotiate around use and talk about the pros and cons of beginning PTSD treatment. So, let me show you an example of what that might look like.

So, that skill set is one that you can and probably should come back to again and again throughout treatments. The person has a lapse or a relapse as we were just talking about, you're going to go back to the use of motivational interviewing to build that desire to move towards healthy changes. Again, talking about pros and cons, talking about what's in it for them to change, and also building this idea that the person has those skills within them. It's a very affirming kind of approach.

Now for somebody where their substance use is a bigger concern for them, or for you, a really good option to think about are concurrent treatment options. So, this is a place where you coordinate with a care provider who's doing focused substance use treatment, but you're making sure that the two of you are working together so you're not giving the patient mixed messages. It's not helpful if the substance use person is saying don't talk about the trauma, and you're saying talk about the trauma. So, it really needs to be coordinated care, but that's actually a really good option when you have folks with dual diagnoses.

It's important to remember that the tools that we use in the trauma focused cognitive behavioral therapies can be helpful in and of themselves to manage substance use. So, for example, you can contract with your client around stopping use, reducing their use, or not using in response to trauma-related material. You want to go back to that treatment rationale. That's the reason for the person to make those changes in their substance use. So, it's avoidance behavior. They can look at, again, that idea around short-term gains, long-term consequences, and also has it really worked to keep those symptoms away since

they're here in your office. You can help the person remember the times that they've been able to tolerate those symptoms without using, and you can think about things like scheduled use.

So, for example, ideally, it's better if people abstain. We have data that if people abstain during Prolonged Exposure, Cognitive Processing Therapy, that their outcomes look good, but some people won't agree to that. So, you have may say, “Well, could you not use before and after session? Can you not use before and after homework? Can you not use in response to trauma symptoms, because all of that's avoidance, and we're working really hard together as a team to get you to stop doing that?” At that point, there's not that much time left for the person to use. So, let me show you an example of how you might ask a patient about their use that could be part of this conversation around contracting.

So, you can also use the Socratic questions to help work on the substance maintaining beliefs. So, for example, the person may say, “I can't cope without having a joint.” Somebody may think, “I'm a lousy person because of the things that I've done when I've been using.” Or someone may say that their substance of choice helps them manage their PTSD. You know, many of us say things like, “You know, I've had a lousy day. I'm going to go have a smoke,” right? Those are all examples of substance maintaining beliefs, and you can use Socratic dialogue to question those just like you do any other cognitive distortion. So, tell me about times you have managed without a smoke or without a joint. Tell me about the times when your substance doesn't help with the PTSD. Does it work every time? If it doesn't work every time, the belief's not accurate.

Thank you, Dr. Kaysen. I’d like to summarize some of the points that I consider most important from what we've presented about serving Veterans with co-occurring SUD and PTSD. These attempted to really change our clinical culture by funding SUD/PTSD specialists at each facility so that they can effectively promote integrated treatment of these disorders across settings. It's essential to have coordinated and systematic assessment that addresses both substance use disorder and PTSD, regardless of whether the Veteran initially presents to the addiction clinic or to the PTSD clinic.

There are a number of treatment recommendations that are based on the existing guidelines for substance use disorders and PTSD. So, being familiar with both the SUD guideline and the PTSD guideline is important. Neither of the guidelines currently recommends a specific treatment of choice for co-occurring substance use disorders in PTSD, and we're hopeful that some of the ongoing studies by some of our colleagues will soon provide us with some evidence in that regard, but right now, it's much more important to find those engagement strategies that will allow a Veteran to get started with the process and to monitor the response, so that, we can determine whether the treatment that they receive is effective for them and to individualize the care to promote their recovery in the most effective way.

The overarching recommendation is that we need to find ways to assure that treatment is delivered in a concurrent and integrated fashion, rather than saying, “First take care of this problem, then we'll talk to you about the condition that you may have considered to be the primary reason why you came to get our services.” I appreciate your efforts to expand your understanding about this common co-occurring condition and to serve the Veterans who can benefit from our services and really show some effective recovery from both disorders.