ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

Agenda

Zoom link to join from PC, Mac, iOS or Android**:** https://echo.zoom.us/j/156261634

Joining by phone ONLY: +1 646 558 8656 or +1 669 900 6833 (US Toll)
Zoom Meeting ID: 156 261 634

For attendance, purposes please text the following code: FOQMEH to 608-260-7097

Session Date: Friday November 15, 2019

Didactic Topic and Presenter:
Trauma in Women with Substance Use Disorder
Lindsey Peterson, MS, CRC - UW Project ECHO ACCEPT Rehabilitation Counselor

Content Experts:
Ritu Bhatnagar, MD and Susan Mindock, CSAC; and Sheila Weix, MSN, RN, CARN

- 12:30 PM: Attendance text-in – Introductions
- 12:45 PM: Case Presentation & Discussion
  - Presenter: Alison Miller, DO – UW Health
- 1:15 PM: Didactic Presentation
  - Presenter: Lindsey Peterson, MS, CRC - UW Project ECHO ACCEPT Rehabilitation Counselor
- 1:30 PM End of Session

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Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

2018-2020

Trauma in Women with Substance Use Disorder

Friday November 15, 2019

Lindsey Peterson, MS, CRC - UW Project ECHO ACCEPT Rehabilitation Counselor

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
Physicians, Physician Assistants, Nurses, Social Workers, Pharmacists and Counselors.

Objectives:
As a result of this educational regularly scheduled series, learners will be able to:

1. Review appropriate opioid prescribing and monitoring practices.
2. Participate in office-based management of substance use disorders.
3. Seek, with greater frequency, overdose prevention education.
4. Identify the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of substance use disorders.

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Name/Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?
Alison Miller Presenter	No relevant financial relationships to disclose	No
Briana Kleinfeldt, RSS Coordinator	No relevant financial relationships to disclose	No
Randy Brown, RSS Chair	No relevant financial relationships to disclose	Yes
Paul Hutson, Content Expert, Pharmacy	Consultant for Projections Research Inc.	Yes
Ritu Bhatnagar, Content Expert, Psychiatrist	No relevant financial relationships to disclose	Yes
Melissa Ngo, Content Expert, Pharmacist	No relevant financial relationships to disclose	No
Susan Mindock, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
Sheila Weix, Content Expert, Nurse	No relevant financial relationships to disclose	No
Lindsey Peterson, MS, CRC, Content Expert	No relevant financial relationships to disclose	No
Dean Krahn, Content Expert	No relevant financial relationships to disclose	Yes
Kim Sprecker, OCPD Staff	No relevant financial relationships to disclose	No

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WISCONSIN DEPARTMENT of HEALTH SERVICES

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Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

1. Date: August 29, 2019
2. Presenter Name: Alison Miller
3. Presenter Organization: UW Health
4. ECHO ID: 8091
5. Have you presented this patient during this teleECHO clinic before? NO
6. PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE:

Patient has Hz of AUD and OUD and would like to stop treatment for addiction. She has been having abnormal urines for the past few months and would like to be able to use cocaine and Xanax on occasion socially or when her anxiety is high. She buys this on the street, not being prescribed. She does not want to have urine tests or go to counseling. Would you stop her Buprenorphine?

Patient Demographic Information:

7. Age: 36
8. Sex: F
9. Education/Literacy: 4 yr. college degree
10. Income source: works PT as a SAC and husband works full time owns his own business
11. Social Factors/History: 4 children

12. **Substance Use History:**
    - Hz of AUD since she was a teenager, by the time she was 21 drinking a pint of vodka a day. Did have a alcohol withdrawal seizure which brought her to hope haven and has been sober now for 10 yrs.
    - Used opioids intermittently. Has been able to use them on occasion. They would give her energy and focus and if she had a lot of house cleaning would use one. During her last pregnancy 2 yrs. ago had low back, was given Oxycodone sparingly #28/month and continued after pregnancy for a few months then the doctor stopped I am not sure why. She then bought them on the street and quickly started using more 3-4 a day. She did not have pain at the time. Being a Substance abuse counselor she knew what to do and bought Buprenorphine on the street and started it on her own. I saw her for a year prescribing 8 mg twice a day. Her urines were always appropriate, she came to visits and no concerns. 6 months ago started having cocaine in her urine. She has been leading groups at her work and a lot of sexual trauma came up for her and cocaine was the only thing that

caused her not to think about her past trauma. She would use every other day. She went to counseling weekly. Private 1:1 counseling and was able to decrease her cocaine use. However she is not interested in completely stopping it. And at times she does want to be able to use Xanax.

- Has used cocaine socially since teenager, never uses regularly always snorted, never used any IV drugs or smoked cocaine
- Regular nicotine use
- Occasional marijuana use

13. Consequences of Substance Use:

- Social/occupational/educational:

  Works PT as a SAC

- Physical (including evidence of tolerance/withdrawal):

  Over the past 6 months has lost 10#'s

14. Interventions that have been tried:

Plan was contingency management. I would have her come every 2 weeks and do a urine if there was no cocaine I would keep her on the same dose if there was cocaine I would lower her buprenorphine by 2 mg. She would continue with the therapist. Did not want to do any groups or IOP since she no one knew she was on buprenorphine. She did this once (came back in 2 weeks) and the next time she told me she did not want to be prescribed buprenorphine anymore and does not want treatment for her addiction. Would like freedom to use cocaine and Xanax socially.

15.

Current Addiction and Mental Health-related Medications:	Medical/Behavioral Health Diagnosis:
• Buprenorphine 8 mg in AM and 6 mg in the PM	• PTSD • Sexual trauma history • Anxiety

16.

Patient Strengths/protective factors:	Risk factors:
•	• Has 4 young kids, her husband does not know she uses cocaine and Xanax. Initially he was not aware she was on Buprenorphine but she finally told him after he found strips

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17. Labs (as indicated), include summary of urine testing or last urine drug screen results:

Urine positive for:

- Benzoylecgonine
- Ethyl Glucuronate
- Alprazolam
- Amphetamine
- Buprenorphine
- Norbuprenorphine

18. Patient Goals/Motivations for Treatment:

Does not want to be in treatment anymore.

19. Proposed Diagnoses:

OUD and AUD in a patient who wants to complete treatment and be weaned off Buprenorphine rather then frequent follow up and therapy

20. Proposed Treatment Plan:

By initialing here __ARM_____ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

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DSM 5 Criteria for Substance Use Disorder

A use disorder is characterized by maladaptive use resulting in repetitive consequences over the previous 12 months. A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (American Psychiatric Association 2013)

1. Taking the substance in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use
5. Repeatedly unable to carry out major obligations at work, school, or home due to use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use in physically hazardous situations
9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

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Trauma in Women with Substance Use Disorder

Lindsey Peterson, MS, CRC

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Introduction

- "Trauma is the ultimate experience of **'this will last forever'**"
- **"**Trauma invariably involves **not being seen, not being mirrored and not being taken into account.**"
- *The Body Keeps the Score by Bessel van der Kolk*

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Overview

- What is the difference between trauma, acute stress, posttraumatic stress, and complex posttraumatic stress?
- Why are women at higher risk for experiencing trauma?
- Why are women at higher risk for developing comorbid PTSD and SUD?
- How closely linked are PTSD and SUD?
- What might trauma symptoms or PTSD symptoms look like in women with SUD?

Trauma

- Spectrum of response to potentially traumatic experiences
- Many trauma survivors experience symptoms that do not meet the diagnostic criteria for ASD or PTSD, but still experience difficulty with:
  - Regulating emotional states
  - Maintaining steady and rewarding social and family relationships
  - Performing competently at a job
  - Maintaining a steady pattern of abstinence in recovery
  - These symptoms can be transient, intermittent, or a part of the individual's regular pattern of functioning
  - Often, these patterns are termed "subthreshold" trauma symptoms
  - Like PTSD, the symptoms can be misdiagnosed as depression, anxiety, etc. *(SAMHSA TIP 57)*

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Acute Stress

- Acute Stress Disorder: represents a normal response to stress
- Symptoms develop within 4 weeks of trauma and can cause significant levels of distress
- Most individuals who have acute stress reactions never develop further impairment or PTSD
- ASD is highly associated with the experience of one specific trauma rather than the experience of long-term exposure to chronic traumatic stress
- The diagnosis of ASD can change to a diagnosis of PTSD if the symptoms persist past 4 weeks
- There is some suggestion that, as with PTSD, ASD is more prevalent in women than in men *(Bryant & Harvey, 2003)*

Posttraumatic stress

Post-traumatic stress disorder: Individuals must have been exposed to actual or threatened death, serious injury, or sexual violence, and the symptoms must produce significant distress and impairment for more than 4 weeks

- Four symptom clusters for PTSD:
  - Presence of intrusion symptoms
  - Persistent avoidance of stimuli
  - Negative alterations in cognitions and mood
  - Marked alterations in arousal and reactivity

(SAMHSA TIP 57)

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Complex posttraumatic stress

- Individuals are more likely to have a history of exposure to several traumatic events rather than a single trauma *(Resnick, Kilpatrick, Dansky, Saunders & Best, 1993)*
- Complex trauma impacts multiple domains including:
  - Affect
  - Attachment
  - Behavior
  - Biology
  - Cognition and perception
  - Self-image, and
  - Academic functioning, in addition to standard PTSD symptoms

Complex posttraumatic stress

- Complex PTSD (CPTSD) includes the core symptoms of PTSD in addition to a range of difficulties in self-regulatory capacities:
  - (a) emotion regulation
  - (b) relational capacities
  - (c) alterations in attention and consciousness *(i.e. dissociation)*
  - (d) adversely affected belief systems
  - (e) somatic distress or disorganization

(International Society for Traumatic Stress Studies)

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Complex posttraumatic stress

- Result of exposure to repeated or prolonged instances or multiple forms of interpersonal trauma
- Often occurs under circumstances where escape is not possible due to physical, psychological, developmental, environmental, or social constraints *(Herman, 1992)*
- Can include childhood physical/sexual abuse, recruitment into armed conflict as a child, being a victim/survivor of domestic violence or sex trafficking, experiencing torture and exposure to genocide or other forms of organized violence
- Symptom profile of Complex PTSD recognizes the loss of emotional, social, cognitive and psychological competencies that either failed to develop properly or that deteriorated due to prolonged exposure to complex trauma *(International Society for Traumatic Stress Studies)*

Trauma, acute stress, posttraumatic stress, and complex posttraumatic stress

- The most common diagnoses associated with trauma are PTSD and ASD
- However, trauma is also associated with the onset of other mental disorders—particularly substance use disorders, mood disorders, various anxiety disorders, and personality disorders
- Trauma typically exacerbates symptoms of preexisting disorders
- Mental disorders can occur almost simultaneously with trauma exposure or manifest sometime after

(SAMHSA TIP 57)

Women and Trauma

- "Being able to move and do something to protect oneself is a critical factor in determining whether or not a horrible experience will leave long-lasting scars." *(van der Kolk, 2014)*
- Early experience with trauma (e.g., a history of childhood sexual or physical abuse) heightens a person's susceptibility for severe PTSD symptoms as an adult
- In addition, victims/survivors of childhood abuse are at higher risk for developing PTSD symptoms following traumatic events in adulthood *(Breslau et al., 1999)*
- Important to consider sexual violence experiences in differentiating between PTSD and CPTSD, with sexual violence more often associated with CPTSD *(Hyland et al, 2017)*

Comorbid SUD and C/PTSD in Women

- Association between PTSD and AUD is particularly strong for women
- A history of sexual abuse can increase the risk of problem drinking to 20x the normal rates of alcohol abuse for both sexes
- However, females were much more likely to have been sexually abused than males and therefore the symptoms of PTSD were more common for females than males with AUD *(Clark et al., 1997)*

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Comorbid SUD and C/PTSD in Women

- In adults, the rates for co-morbid PTSD and SUD are 2-3x higher for females than males, with 30-57% of all female substance abusers meeting the criteria for PTSD *(Najavits et al., 1997)*
- Women compared to men were more than twice as likely to meet criteria for PTSD and for CPTSD
- Cumulative childhood interpersonal violence was a stronger predictor of CPTSD than of PTSD. CPTSD was associated with greater comorbid symptom burden and substantially lower psychological well-being *(Karatzias et al., 2018)*

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Link between C/PTSD and SUD

- High rates of co-morbid PTSD and substance misuse have been reported in a number of epidemiological studies *(Kessler et al., 1995; Kilpatrick et al., 2000; Creamer et al., 2001)*
- Alleviation of the negative affect may be one motivation for individuals with SUD and PTSD to continue using substances *(Logrip et al, 2012)*
- Substances such as alcohol and benzodiazepines are associated with memory impairments, supporting the idea that some people may use drugs to facilitate dampening and forgetting of traumatic memories *(Stewart et al., 1998)*

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Link between C/PTSD and SUD

- Emotional numbing is not simply avoidance that provides protection against painful emotions, but an inability to feel both negative and positive emotions—as a result of emotional exhaustion due to prolonged hyperarousal *(Kashdan, Elhai & Frueh, 2006; Litz, Orsillo, Kaloupek & Weathers, 2000; Litz et al., 1997)*
- Individuals with co-morbid PTSD and SUD report increased craving for alcohol and cocaine following exposure to personalized trauma cues, in the absence of cues related to drugs and alcohol *(Coffey et al, 2002)*
- Supports the importance of trauma-related memories in ongoing drug use

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Link between C/PTSD and SUD

- Prior PTSD, compared with no trauma history, has been associated with 4.9x increased risk of emergence of SUD after controlling for common risk factors including childhood conduct problems, risk taking, and family socioeconomic status *(Reed, Anthony, & Breslau, 2007)*
- A large body of evidence supports the role of stress in initiation and maintenance of drug use behavior. In animal studies, induction of physical or psychological stress facilitates initiation of drug self-administration and facilitates relapse to drug use *(Koob, 2008; Sinha, 2008)*

Link between C/PTSD and SUD

- "Endorphin compensation hypothesis": people use alcohol following a traumatic experience in an attempt to relieve the endorphin deficiency
- Use of alcohol creates a cycle in which more alcohol is needed to prevent subsequent endorphin withdrawal symptoms
- Special populations, such as women, may be at particular risk for trauma-induced, co-occurring SUD and C/PTSD *(Volpicelli et al., 1999)*

Link between C/PTSD and SUD

- Self-medication—(substance abuse)—is one of the methods that traumatized people use in an attempt to regain emotional control, although ultimately it causes even further emotional dysregulation
- This method can provide a false and paradoxical feeling of control that was absent during a traumatic experience
- Relationships between PTSD and substance use disorders is thought to be bidirectional and cyclical: substance use increases trauma risk, and exposure to trauma escalates substance use to manage trauma-related symptoms *(SAMHSA TIP 57)*

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Symptoms of Trauma in Women with SUD

- When something reminds traumatized people of the past, their right brain reacts as if the traumatic event were happening in the present
- Because their left brain is not active, they may not be aware that they are re-enacting the past; they are just furious, terrified, enraged, ashamed or frozen
- When the emotional storm passes, they may look for something or somebody to blame for it or believe their reaction is someone else's fault *(van der Kolk, 2014)*

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Symptoms of Trauma in Women with SUD

- "As long as the trauma is not resolved, the stress hormones that the body secretes to protect itself keep circulating, and the defensive movements and emotional reactions keep getting replayed. They have no idea why they respond to some minor irritation as if they are about to be annihilated." *(van der Kolk, 2014)*
- Undergoing detox without diagnosis and management of PTSD symptoms may result in a cycle in which the PTSD symptoms, which were controlled by substance use, return when the individual is drug-free and perpetuate a relapse *(Reynolds et al, 2005)*

Symptoms of Trauma in Women with SUD

- In a 2004 study, trauma memories were reported as becoming more vivid after creasing drug use by 61.7% of the sample; 61.3% reported experiencing an increased frequency of trauma memories; and 38.2% reported that trauma memories become more distressing after stopping drugs *(Reynolds et al., 2004)*
- Trauma often occurs under conditions of no personal control and individuals who have experienced traumatic events may subsequently attempt to overcompensate by being in control of as many aspects of their life and experience as possible *(Orsillo & Roemer, 2005)*

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Symptoms of Trauma in Women with SUD

- Risk of misinterpreting trauma-related symptoms in substance abuse treatment settings
- Avoidance symptoms in PTSD can be misinterpreted as lack of motivation or unwillingness to engage in treatment
- Efforts to address substance abuse-related behaviors in early recovery can provoke an exaggerated response from a trauma survivor who has profound traumatic experiences of being trapped and controlled
- Some clients in recovery only begin to experience trauma symptoms when they maintain abstinence for some time. As they decrease tension-reducing or self-medicating behaviors, trauma memories and symptoms can emerge

(SAMSHA TIP 57)

Conclusion

- Research on post-traumatic growth and resiliency
- Resiliency Quiz
  - https://www.resiliency.com/free-articles-resources/the-resiliency-quiz/
- Stay tuned: Trauma-Informed Care Treatment presentation on January 17, 2020

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DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} Physical Dependence ≠ Use Disorder

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2–3 = mild
4–5 = moderate
$\geq$ 6 = severe

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