An Integrated Approach to PTSD and SUD Using COPE

Session Goals

- Increase knowledge of the symptoms and effects of PTSD.
- Learn about the relationships between PTSD and substance use disorders.
- Learn about Prolonged Exposure Therapy.
- Learn about an integrated approach, COPE, to help patients with the co-occurring disorders.
- Understand in-vivo and imaginal exposure therapy procedures.
- Identify measures for assessing progress in PTSD/Substance abuse treatment using COPE.
PTSD DSM 5 Criteria

- Four clusters:
  - Intrusion,
  - Avoidance,
  - Negative alterations in cognitions and mood—persistent and distorted blame of self or others, and persistent negative emotional state
  - Alterations in arousal and reactivity—reckless or destructive behavior.
- Subtype “with dissociative symptoms”
  - Depersonalization and derealization.

Trajectory Following Trauma

- Resistance
  - Distress and dysfunction are absent and there is no immediate or long-term effect of a traumatic event.
- Resilience
  - Distress reactions are transient and there is a rapid return to functioning after an event.
- Recovery
  - Similar to resilience, except that the return to pre-event functioning does not happen as rapidly.
- Chronic dysfunction = PTSD
  - Absence of resistance, resilience, and recovery.

Natural Recovery

- Behavioral and cognitive engagement promotes natural recovery.
- Processing that occurs over the course of everyday life:
  - Sharing memories, thoughts, and feelings with friends helps digest and process the event without extreme distress or anxiety.
  - Sharing thoughts and memories about the trauma with family and friends may increase support and resources that promote resilience or recovery.
- People who approach rather than avoid situations that remind them of the trauma learn that these situations are not harmful.
Failure of Natural Recovery

- Trauma survivors who engage in cognitive and behavioral avoidance may maintain unrealistic beliefs about the world and themselves.
- Level of functional impairment, co-morbidity, and somatization are associated with higher levels of chronicity and intensity of PTSD.
- Prolonged Exposure parallels the natural recovery process.
- Promotes engagement with feared memories, situations, people, places, and things and provides opportunities for learning.

Substance Use in PTSD

- According to a national study, 46.4% of individuals with lifetime PTSD also met criteria for SUD.
- 27.9% of women and 51.9% of men with lifetime PTSD also had SUD.
- Women with PTSD were 2.5 times more likely to meet criteria for alcohol abuse/dependence and 4.5 times more likely to meet criteria for drug abuse/dependence than women without PTSD.
- Men were 2 and 3 times more likely, respectively.

PTSD and SUD Among Veterans

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2005</th>
<th>2008</th>
<th>2010</th>
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<tr>
<td>SUD</td>
<td>301,483</td>
<td>594,130</td>
<td>362,137</td>
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<tr>
<td>Alcohol</td>
<td>702,793</td>
<td>189,889</td>
<td>219,173</td>
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<tr>
<td>Opioid</td>
<td>30,540</td>
<td>58,008</td>
<td>60,510</td>
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<td>Cocaine</td>
<td>74,986</td>
<td>71,271</td>
<td>80,448</td>
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<tr>
<td>Amphetamine</td>
<td>943</td>
<td>10,340</td>
<td>11,912</td>
</tr>
<tr>
<td>Cannabis</td>
<td>40,989</td>
<td>62,256</td>
<td>75,887</td>
</tr>
<tr>
<td>Conventional SUD/low PTSD</td>
<td>77,556 (29%)</td>
<td>61,164 (27.4%)</td>
<td>105,089 (20.9%)</td>
</tr>
</tbody>
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Note: Numbers reflect patients seen in Veterans Affairs medical centers with various substance abuse diagnoses, 2006-2010.
Concurrent Treatment of PTSD and Substance Use Disorders with Prolonged Exposure

Employs imaginal and in vivo exposure along with relapse-prevention therapy and psychoeducation on PTSD symptoms.

According to Killeen and co-authors, recent studies, including one randomized controlled trial, indicate that participants in COPE experienced improved PTSD and substance use outcomes.

COPE

- 12 x 90 minute sessions for 12 weeks
- Provide psychoeducation around the relationship between SUD and PTSD,
- Provide the patient with SUD coping skills to manage cravings and high-risk thoughts and situations,
- Participate in imaginal and in-vivo exposures for PTSD, and
- Address the PTSD and SUD in an integrated manner throughout.

COPE Sessions

Fear is encoded in memory as a cognitive structure that includes:

- representations of the feared stimuli
- physiological responses
- meaning associated with the feared stimuli
  - I will die
  - fast heart rate means I'm afraid.
- In an actual life-threatening situation, the fear structure operates as an adaptive program for escaping danger.

Emotional Processing Theory
PTSD represents a pathological fear structure. It involves excessive escape/avoidance elements that are triggered by harmless stimuli and interfere with adaptive functioning, are resistant to modification, include associations among the different elements that do not accurately represent reality. In PTSD the pathological associations are: safe situations that are perceived as dangerous, anxiety and distress responses are perceived by the patient as signs that he/she is incompetent.

Fear structure in treatment: Intervention requires modification of the pathological elements of the fear structure. Modification requires two conditions: 1) activation of the fear structure, 2) availability of incompatible information. In vivo and imaginal exposure satisfy these two conditions. Confrontation with trauma-related stimuli activates the fear structure in a safe context, and Patient learns that the expectation about being harmed were inaccurate and that he/she is able to tolerate the anxiety and is not incompetent.

Psychoeducation
Describe PTSD symptoms and associated features: fear and anxiety, re-experiencing symptoms (e.g., nightmares flashbacks), avoidance, emotional numbing (e.g., feeling alienated from friends and loved ones), and increased arousal (e.g., anger, irritability, sleep problems) guilt and shame, grief and depression, negative self-image and views of the world, problems with intimacy and sexual relationships, and use of alcohol or drugs as coping strategies.
Treatment for PTSD involves
- slowly taking things out of the cupboard
- examining them carefully
- folding them neatly
- putting them back in the right place

In this way, memories of the traumatic event find their proper place: you can find them if you choose to, but they won’t come back so often when you don’t want them to. If they do, you know what to do.

Targets avoidance and unhelpful beliefs
- Avoidance and unhelpful beliefs get in the way of your patient’s ability to process or “make sense” of the trauma.
- Prolonged Exposure involves confronting the trauma through two types of exercises:
  - In vivo exposure (“just doing it”) and
  - Imaginal exposure (“talking about it”).
**Therapeutic Alliance**

- Acknowledge courage for coming for treatment.
- Communicate understanding of symptoms.
- Validate your patient’s experience in an empathetic and non-judgmental manner.
  - This may be the first time your patient has disclosed significant details about the trauma to anyone.
- Work collaboratively.
  - Incorporate your patient’s judgment about pace and targets of therapy.

**Steps**

- Assessment
- Contract with SMART goals
- Family involvement
- Psychoeducation on PTSD and SUD
- Offer coping skills on cravings & triggers
- Explain breathing retraining and homework
- Explain SUDs and how to use them
- Develop the Fear Hierarchy
- Begin exposure work
- Endings

**Breathing**

- In a life or death situation, we switch to “fight-or-flight mode.” We take shorter, quicker breaths to fuel our bodies with the oxygen it needs to escape or defend itself from danger.
- PTSD is like being in chronic “flight-or-fight mode”- like always being on high alert, or on the lookout for danger.
- Taking slower, longer breaths can have a calming effect and promote relaxation.
- Practice
Rate his/her anxiety level during in vivo and imaginal exposure exercises
- SUDs ratings range from 0 (no distress, very relaxed) to 100 (highest distress).
- Select anchor points to help your patient figure out how to use the scale
- Do NOT to generate anchor points directly related to the trauma
- “How much discomfort do you feel right now as we are talking?”

Homework
- Homework is assigned at every session.
- Assignments include:
  - completing in vivo exposure exercises,
  - listening to session and imaginal exposure audiotapes,
  - practicing breathing retraining, and
  - reviewing informational handouts about PTSD, common reactions to trauma, and Prolonged Exposure therapy.

Creating the Fear Hierarchy
- Have your patient generate a list of 15 to 20 feared and avoided situations and activities.
- Assign SUDs ratings.
- Ensure that activities selected for homework are feasible and accessible.
- Ensure that activities selected for homework are objectively quite safe.
- Instill confidence by identifying your patient’s successful experiences with natural exposure.
**In Vivo Exposure-Purpose**

- Break problematic avoidance.
- Foster realization that the avoided situation is quite safe
- Disconfirm belief that anxiety in the feared situation will continue forever
- Disconfirm belief that he/she cannot tolerate the stress and anxiety
- Enhance sense of self-control and competence
- Reduce feelings of alienation and loss of interest in activities by promoting engagement in positive activities, hobbies, and relationships enjoyed prior to the trauma

**In Vivo Exposure-Procedure**

1. Present rationale for the in vivo component
2. Create a fear hierarchy of 15 to 20 trauma-related situations/activities that are objectively safe or have very low probability of being harmful, but trigger distress in order to break patterns of avoidance
3. Identify positive or valued activities your patient used to enjoy prior to the treatment.
4. Assign selected activities from the hierarchy for homework

**Implementing In Vivo Exposure**

1) **Build confidence.** Set your patient up for success by selecting activities they are likely to master for the first assignment.
2) **Promote habituation.** For in vivo exposure to be effective, your patient should remain in the situation long enough for habituation to occur. Instruct patients to remain in each situation until initial SUDs levels have decreased by at least 50%, and remained at that level (or lower) for at least 30-40 minutes.
3) **Monitor SUDs.** Patient should record SUDs before and after the exposure as well as his peak or highest level of distress.

4) **Plan in vivo assignments.** The last 10 to 15 minutes of each session select and plan the upcoming in vivo exposures.

5) **Review in vivo assignments.** The first 10 minutes of each session review homework. Identify patterns of change and highlight evidence of habituation. Praise your patient for completing the assignment.

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**Imaginal Exposure**

- Patient revisits the trauma memory, providing a detailed verbal account that includes sensory information, thoughts, feelings, and reactions experienced during the trauma.
- Designed to promote patient’s emotional engagement with the trauma memory by talking about the trauma in her own words.
- Provide a safe, supportive, and empathetic presence as she revisits the memory. Probe for thoughts and feelings as necessary, in general, keep comments to a minimum.

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**Approach to Imaginal Exposure**

- **Remind your patient of the beginning and end points of the trauma memory.**
  - These should that serve as anchors (i.e., where the patient begins and ends telling the memory) for the narrative during the imaginal exposure.

- **Instruct your patient to:**
  - Begin the narration from about 5 minutes before the trauma actually occurred.
  - Recount the memory with eyes closed.
  - Recount the memory in the present tense.
Recount the memory with as many details as s/he can, including sensory details, thoughts, and feelings.
Engage in the feelings that the memory elicits.
Remain engaged in the narration for 45 min, repeating the narrative as many times as necessary to satisfy this duration.
Report SUDs ratings every 5 minutes.
Collect SUDs ratings from your patient every 5 minutes.
Record ratings on the Imaginal Exposure SUDs Recording Form.

Allow sufficient time for processing.
- After about 45 minutes of imaginal exposure, process the experience with your patient.
- 15 to 20 minute dialogue with your patient about his reactions to revisiting the trauma that occurs after every imaginal exposure exercise.
In later sessions, focus the imaginal exposure on hot spots.
- Hot spots are the areas of the trauma narrative that produce the most distress.

During Imaginal Exposure
Express empathy/provide safe and supportive presence.
- Offer empathetic statements: “You’re doing a great job. Stay with it.” If patient is distressed and/or crying, reassure patient: “This is hard, but you are safe.”
Minimize comments.
- If patient is appropriately engaged with the memory and is proceeding with the exercise as instructed, keep comments to a minimum.
Probe for thoughts and feelings as necessary.
- Avoid “autopilot,” describing details in a rote fashion and avoiding thoughts and feelings. Prompt “How are you feeling now?” or “What are you thinking now?”
- Discourage “editorializing.”
  - These comments interfere with engaging and processing the trauma memory.
  - Redirect your patient to describe the behaviors, thoughts, and feelings they experienced during the trauma.
- Titrate the exercise based on the patient’s emotional response.

Check for Triggers & Cravings
- Management of Hot Spot triggers
  - Develop emergency safety plan
  - May involve trusted family, friend, or sponsor
  - Identify level of cravings during and after hot spot triggers
    - Use SUDS like scale or 1-10
  - Check in to see if patient is aware of thought, feelings, behaviors during exercise
  - Support progress throughout

Imaginal Exposure Sessions
- Initial sessions
  - the primary objective is to have the patient revisit the traumatic memory in as much detail as possible.
- Mid-treatment or “hot-spot” sessions.
  - focus the imaginal exposure on “hot-spot” areas of the narrative—those that produce the most distress to your patient.
- The final exposure session.
  - revisit the entire trauma one time
  - ascertain the degree of habituation and organization of the memory.
Endings

- Review progress in each stage of treatment,
- Get their feedback on their progress, what works for them, ask them to assess how their support system has changed, how their perspectives have changed,
- Review plan to manage any setbacks,
- Offer support and praise for their hard work.

Info on PET and SUD/PTSD Scales

- PEWeb (2014). *Prolonged Exposure for PTSD*, Medical University of South Carolina, from http://pe.musc.edu/
- Substance Use and Co-Morbid Disorders
- Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)

References