PTSD, Addictions and Veterans

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Post Traumatic Stress Disorder and co-morbidities

Aims of this talk:

- Definitions
- Prevalence
- Addictions
- Treatment

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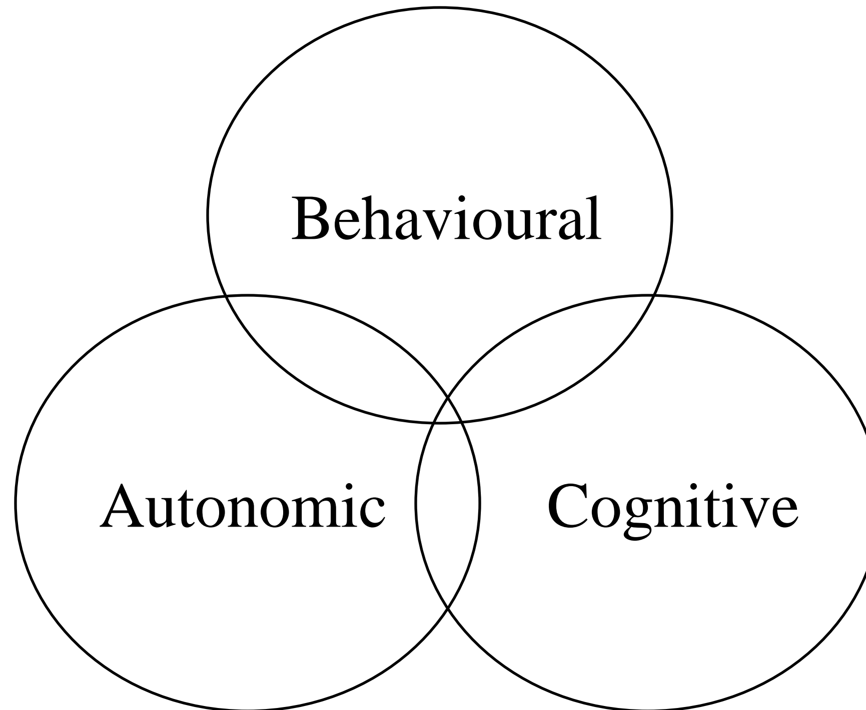
Three Systems of Anxiety



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BEHAVIOURAL RESPONSES
(avoidance, escape or modification)

↑

Anxiety

PHYSIOLOGICAL RESPONSES

- palpitations
- sweating
- dizziness
- breathlessness
- choking
- visual disturbance
- nausea
- muscular tension
- tremor
- malaise
- dry mouth

COGNITIVE RESPONSES

- fearfulness
- madness
- foolishness
- illness
- sense of failure
- impending doom
- inadequacy
- inability to cope

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Anxiety Disorders (DSM-1V)

- Panic Disorder
- Agoraphobia
- Specific Phobias
- Social Phobia
- Post Traumatic Stress Disorder
- Obsessive Compulsive Disorder
- Generalised Anxiety Disorder

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Anxiety Disorders (DSM-V)

- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Panic Disorder
- Agoraphobia
- Generalised Anxiety Disorder
- Substance/Medication-Induced Anxiety Disorder
- Anxiety Disorder Due to Another Medical Condition

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DSM-V (New Category)

Trauma- and Stressor-Related Disorders

- Posttraumatic Stress Disorder (> 1 month)
- Acute Stress Disorder (< 1 month)
- Adjustment Disorders

Post-Traumatic Stress Disorder

- Has **experienced** or **witnessed** or was **confronted** with an unusually traumatic event that has both of these elements:
  - event involved actual or threatened death or serious physical injury to the person or **others**, and
  - felt intense fear, horror or helplessness

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Post-Traumatic Stress Disorder

Diagnosis

1. Intrusion - re-experiencing thoughts, intrusive flashbacks, vivid memories, recurring dreams
2. Avoidance - Distress on re-exposure, leading to avoidance of similar circumstances
3. Hyperarousal – anxious, hypervigilance, sleep disturbance, irritability
4. Negative thoughts and mood. – guilt, emotional numbness, detachment,

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Post Traumatic Stress Disorder

- Specifier:

  Dissociation ie derealisation or depersonalisation

Severity affected by

- Premorbid mental or psychological problem
- Repeated similar stress
- **Human agency** – more severe if stressor caused by another person ie assault (sexual), war

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Prevalence

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National Survey Mental Health & Wellbeing (NSMH&WB) 1997, 2007

Prevalence of Mental Illnesses

(Australia; 12 month rate; adults 16-85yrs)

	1997		2007	
	Male	Female	Male	Female
Anxiety Disorder	7.1%	12%	11%	18%
Substance Use Disorder	11%	4.5%	7%	3.3%
Affective Disorder	4.2%	7.4%	5.3%	7.1%
Lifetime prevalence of schizophrenia	0.4 - 1.5%			

Source: 1997 National Survey of Mental Health and Wellbeing: Adult Component (ABS1996)
2007 National Survey of Mental Health and Wellbeing: Summary of Results (ABS 2008)

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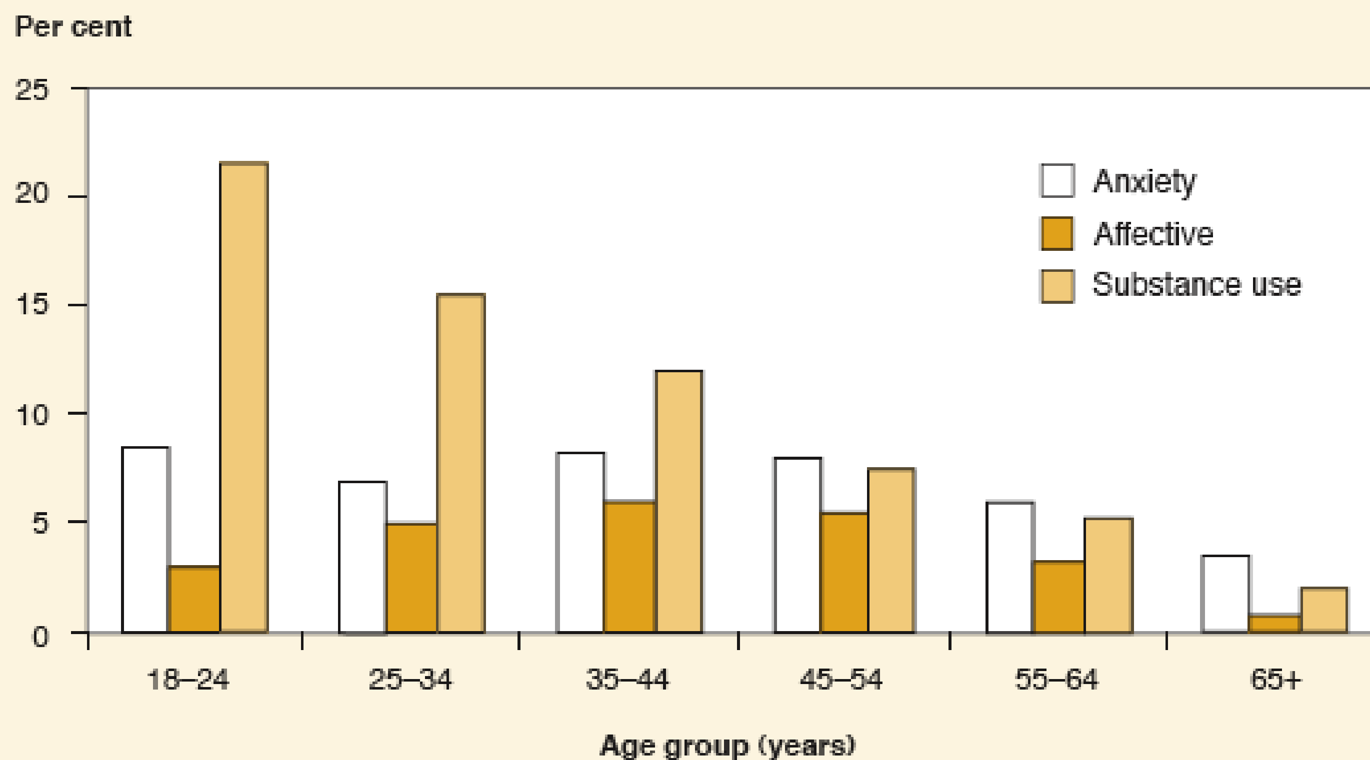

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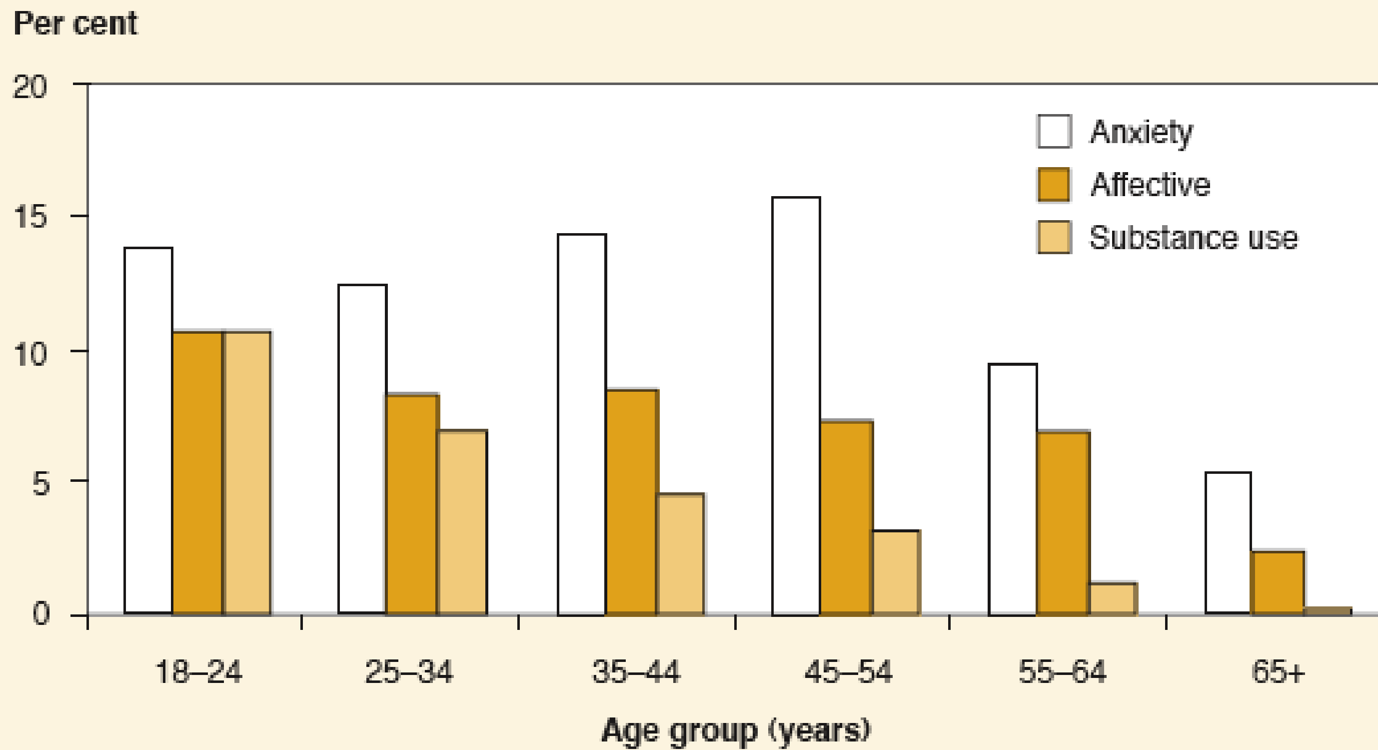

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Prevalence of Anxiety Disorders

	TAD	PD	AG	SOC	SPEC	OCD	PTSD	GAD
1-yr*	10.6	0.99	1.6	4.5	3.0	0.54	1.2	2.6
LT*	16.6	1.9	3.8	3.6	5.3	1.3	2.1	6.2
AUS 1-yr**	14.4	2.6	2.8	4.7		1.9	6.4	2.7
AUS LT	26.3	5.2	6.0	10.6		2.8	12.2	5.9

* Somers et al. 2006. Prevalence and incidence studies of anxiety disorders: a systematic review of the literature. *Canadian Journal of Psychiatry*, 51(2), 100-112
** 2007 National Survey of Mental Health and Wellbeing: Summary of Results (ABS 2008)

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ADF mental health and wellbeing study

(McFarlane et al)

- Anx disorders lifetime - 27% (23%)
- Anx disorders 12 month - 14.8%(12.6%)
- Alcohol lifetime – 35%(32%)
- Alcohol 12 month – 5.2% (8.3)

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Older adults and PTSD

- 70% to 90% of adults aged 65 and above have been exposed to **at least one potentially traumatic event** during their lifetime
- The lifetime prevalence of PTSD in the general adult population is about **8%**
- Current PTSD in adults over 60 is **1.5% to 4%,**
- 2% to 17% current PTSD among US military
- Older adults - sub-clinical levels of current PTSD symptoms ranges from **7% to 15%**

Older adults and PTSD

Older men:

Ex-POWs of WWII and Korea (age = 71)

- lifetime prevalence of PTSD - 53%
- Current PTSD - 29%

Older women - 72% experience interpersonal trauma (e.g., childhood physical or sexual abuse; rape)

- higher rates of trauma are related to increased psychopathology
- Middle-aged and older women are more likely than younger women to have experienced intimate partner violence

PTSD and co-morbidity

- PTSD co-occurs with substance use disorders, major depression, post-concussive symptoms (mild TBI), and chronic pain.
- Aging and PTSD is associated with poorer self-rated health, multiple medical problems - cardiac, gastrointestinal and musculoskeletal disorders
- Cognitive problems: those with PTSD were almost twice as likely to develop dementia

PTSD and alcohol (Nicola Fear et al, A systematic review of the comorbidity between PTSD and alcohol misuse, 2014)

- The prevalence of comorbid alcohol misuse in those with PTSD ranged from 9.8 to 61.3 %.
- The prevalence of comorbid PTSD in those with alcohol misuse ranged from 2.0 to 63.0 %,
- Majority of prevalence rates were over **10.0 %**.
- Alcohol misuse associated with
  - avoidance/numbing symptoms
  - hyperarousal symptoms

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How common is PTSD among TC clients?

	TC's	Maintenance therapy	Detox	Non-treatment
Percent	52	42	37	30

* TC's vs Detox; * TC's vs Non-treatment

Mills et al. (2005). Post traumatic stress disorder among people with heroin dependence in the Australian Treatment Outcome Study (ATOS): Prevalence and correlates. Drug and Alcohol Dependence; 77(3): 243-249.

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Statewide Gambling Therapy Service

Age Group	Frequency: n (%) (n=539)
18-35 years	156 (28.9%)
36-50 years	195 (36.2%)
51-64 years	144 (26.7%)
65+ years	44 (8.2%)

Problem Gambling

Length of (problem) gambling career	Frequency: n (%)
Up to 3 months	10 (2%)
3-12 months	36 (7%)
1-2 years	55 (11%)
2-5 years	97 (20%)
5-10 years	117 (24%)
Over 10 years	175 (36%)

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Problem Gambling

Amount spent on Gambling in last week	Frequency: n (%)
$0	91 (31.8%)
$1-$100	41 (14.4%)
$101-$200	30 (10.4%)
$201-$500	63 (22.1%)
$501-$1000	30 (10.4%)
$1001-$1500	13 (4.5%)
Over $1500	18 (6.3%)

PTSD treatment

Psychological treatment

- Counseling
- Anxiety management (for non-specific symptoms)
- "Trauma-focused CBT"
  - Behaviour therapy (exposure - where intrusive imagery and avoidance present)
  - Cognitive therapy (trauma processing or CPT)
  - EMDR

  [Australian Centre for Post Traumatic Mental Health *www.**acpmh**.unimelb.edu.au/*]

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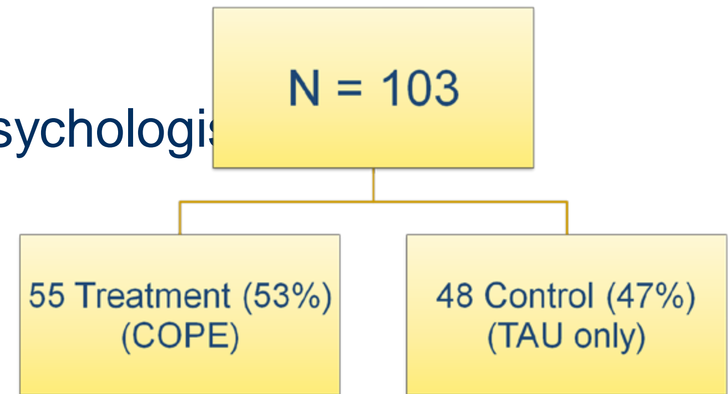
Treating PTSD

- NDARC leading randomised controlled trial of an integrated treatment for PTSD and SUD called Concurrent Treatment with Prolonged Exposure (COPE)
- ***Sessions:*** 13 sessions with a clinical psychologist
- ***Format:*** Individual
- ***Program:*** CBT with imaginal and *in vivo* exposure



Both groups may receive treatment as usual for their substance use in the community (e.g., detox, residential rehabilitation, maintenance pharmacotherpies, counselling etc)

Katherine L Mills[1], Maree Teesson[1] , Emma Barrett[1], Sabine Merz[1], Julia Rosenfeld[1], Philippa Ewer[1], Claudia Sannibale[1], Sally Hopwood[2], Amanda Baker[3], Sudie Back[4], Kathleen Brady[4]

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[3] Centre for Brain and Mental Health Research, University of Newcastle
[4] Department of Psychiatry, Medial University of South Carolina

Concurrent treatment of PTSD and substance use disorders using prolonged exposure (COPE) :

Katherine Mills, et al., National Drug and Alcohol Research Centre, Sydney 2012.

- **13 Therapy sessions**
  Integrates CBT for PTSD with SUD e.g. craving management whilst doing in vivo exposure.

  Components
- symptom assessment for PTSD and SUD
- motivational interviewing
- conceptualisation of CBT model for SUD and PTSD
- breathing retraining
- coping with cravings
- cognitive therapy for SUD
- exposure therapy for PTSD (in vivo and in imagination)
- problem solving

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Severity of PTSD symptoms

Mean CAPS score

100
80
60
40
20
0

89.4
91.1
75.1
67.0
73.0
67.0
68.9
50.2

Baseline
6 wks
3mths
9 mths

Control
Treatment

"It was really really great! I used to wonder how I would cope emotionally without smoking - now I don't have to do that anymore - I'm so glad I did it"

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

A reduction of 15 points on the CAPS total score is considered clinically significant

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Conclusion

- Across the 9 mth follow-up period:
  - Both groups evidenced improvements in their
    - Substance use
    - Severity of dependence
    - PTSD symptoms
    - Depression
    - Anxiety
    - General mental health

  THEY DID NOT GET WORSE!

  - Participants randomised to **COPE** demonstrated significantly greater improvements in relation to their PTSD symptoms, particularly in relation to their avoidance and hyperarousal symptoms
- These findings provide evidence in support of treating PTSD among people with SUDs using COPE (Mills et al., 2007).

Treatment via CBT

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Cognitive Behaviour Therapy

- Behaviour Therapy: A structured therapy derived from learning theory that seeks to solve problems and relieve symptoms by **changing behaviour**.

- Cognitive therapy: A structured treatment approach derived from cognitive theories that seeks to solve problems and relieve symptoms by **changing thought processes**.

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Exposure = HABITUATION

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- In order for the fear to be extinguished the client has to be exposed to the feared stimuli and not to escape, once exposure has commenced, and until the anxiety level declines significantly.

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Habituation

Habituation is more likely when exposure is more:

REGULAR

SYSTEMATIC

PROLONGED

Habituation is most likely to occur by prolonging the period during which the avoidance response is prevented and there is continued exposure to the evoking stimulus without the patient being distracted.

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Exposure - Four principles

- Graded
- Focused
- Prolonged
- Repeated

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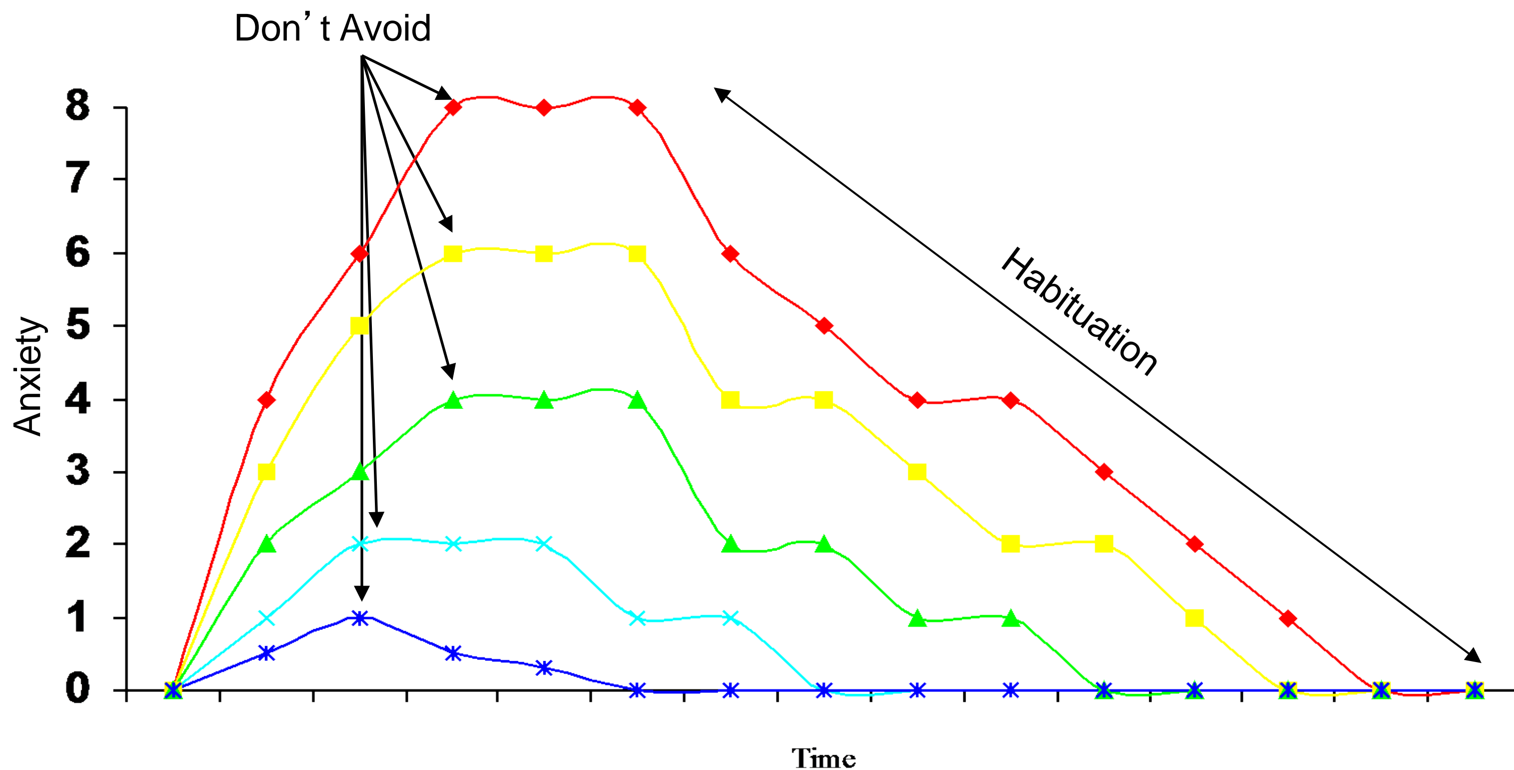
Graded Exposure - Habituation



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Live

- If Possible, self-exposure in vivo needs to be attempted
- The development of the exposure model involved the move to live "in vivo" exposure with the emphasis on self exposure rather than therapist guided exposure.
- Of equal importance is the homework performed between sessions by the patient, again with the emphasis on self exposure

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Imagination

- Fantasy exposure may need to be considered when the real stimuli is either too difficult or impossible to create, for example natural disasters.
- Watching films, viewing pictures or props, listening to audio-recordings may also be of use if recreating the stimuli or situation is too difficult.

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Current Practice

- Therapist is educator, patient takes control
- Weekly/fortnightly contact with therapist
- Co-therapist encouraged
- Exposure for up to1-2 hours daily
- Anticipate setbacks
- Continue task until at least 50% reduction in anxiety

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Resources

- http://www.nice.org.uk/
- http://www.anxietyonline.org.au
- http://ndarc.med.unsw.edu.au
- http://www.cci.health.wa.gov.au/
- **http://at-ease.dva.gov.au/professionals/assess-and-treat/ptsd**
- *www.**acpmh**.unimelb.edu.au/*

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The End

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