Co-Occurring Disorders: Post Traumatic Stress and Personality Disorders

Lori Raney, MD
Principal, HMA

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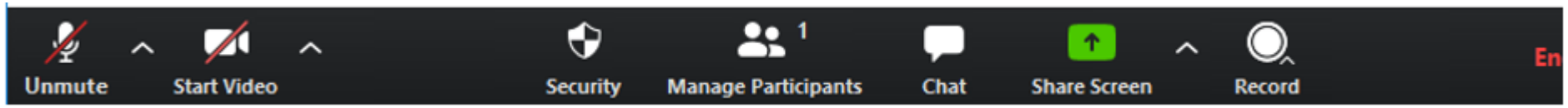
DISCLAIMER

- This session was conducted for members of county-based teams in CA that are working to expand access to Medications for Addiction Treatment in jails and drug courts. The project is funded through California's Department of Health Care Services with State Opioid Response funding from SAMHSA. The content is being made available to all interested parties.
- Please note this content has not been professionally edited and the session was conducted using Zoom.

ZOOM FEATURES

- The preferred audio is using “Phone Call” and enter your participant ID so that your name is associated with your phone number
- Use the “Chat” feature to type in a question or make a comment
- Q&A will start after all three counties have presented
- Use the “Raise Your Hand” feature by going to Manage Participants. You will see your name and can raise your hand
- Polling questions will be used



PRESENTER

Lori Raney, MD
Principal
Denver

LEARNING OBJECTIVES

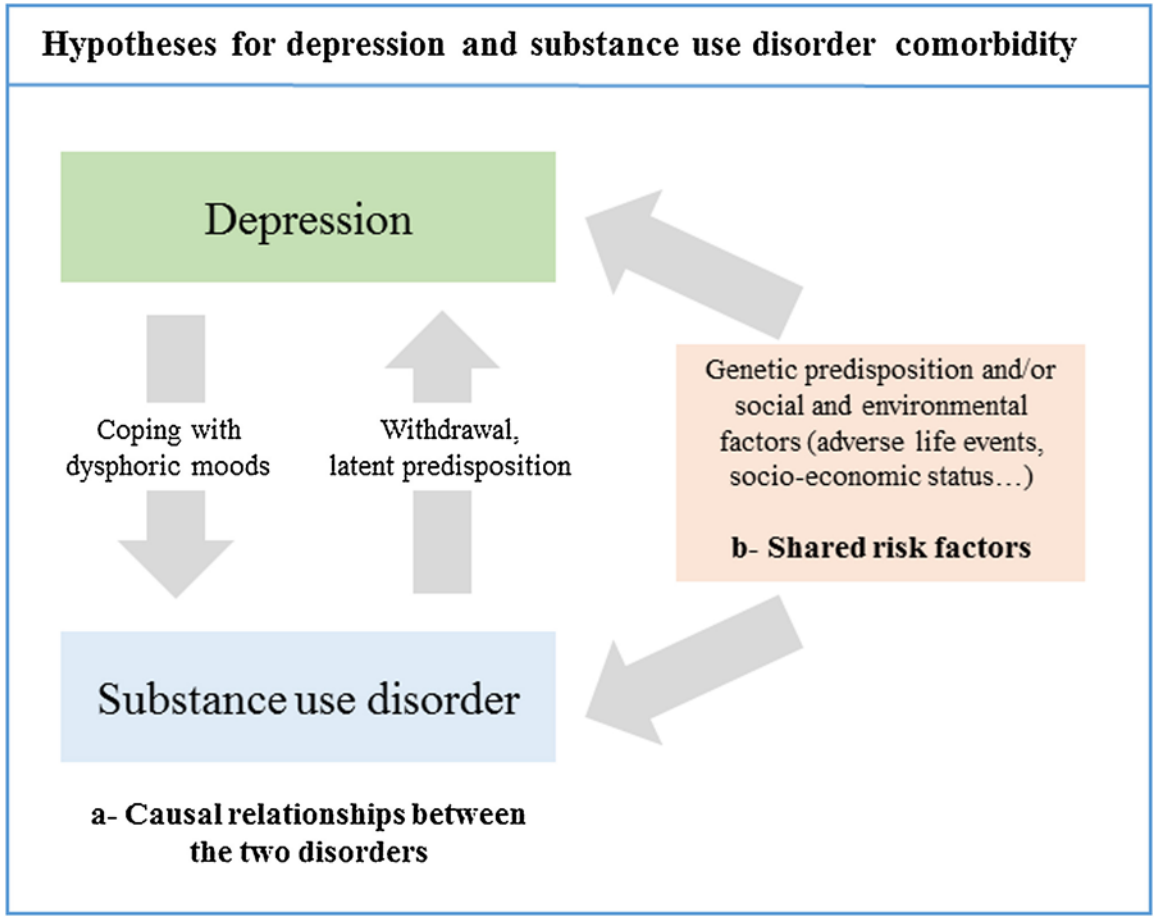
1. Describe the core features associated with post traumatic stress disorder (PTSD)
2. Articulate benefits of addressing substance use disorders (SUD) for PTSD and the benefits of addressing PTSD for SUD
3. List the key elements of successful treatment of PTSD
4. Recognize the relationship between trauma and personality disorders (PD)
5. Identify the need for addressing SUD in people with PD and PD in individuals with SUD
6. Know several approaches to treatment of personality disorders

KEY THEMES OF CO-OCCURING DISORDERS (COD)

- COD is a mental health condition and substance use condition “co-occurring” meaning at the same time
- CODs are common in correction settings – 50-60 % and screening for both is necessary
- CODs lead to enormous dysfunction, repeat incarceration, suffering and death
- CODs are treatable inside and outside correction settings
- Treatment by the same staff in the same setting to address both conditions is the most effective approach (integrated dual diagnosis treatment IDDT)

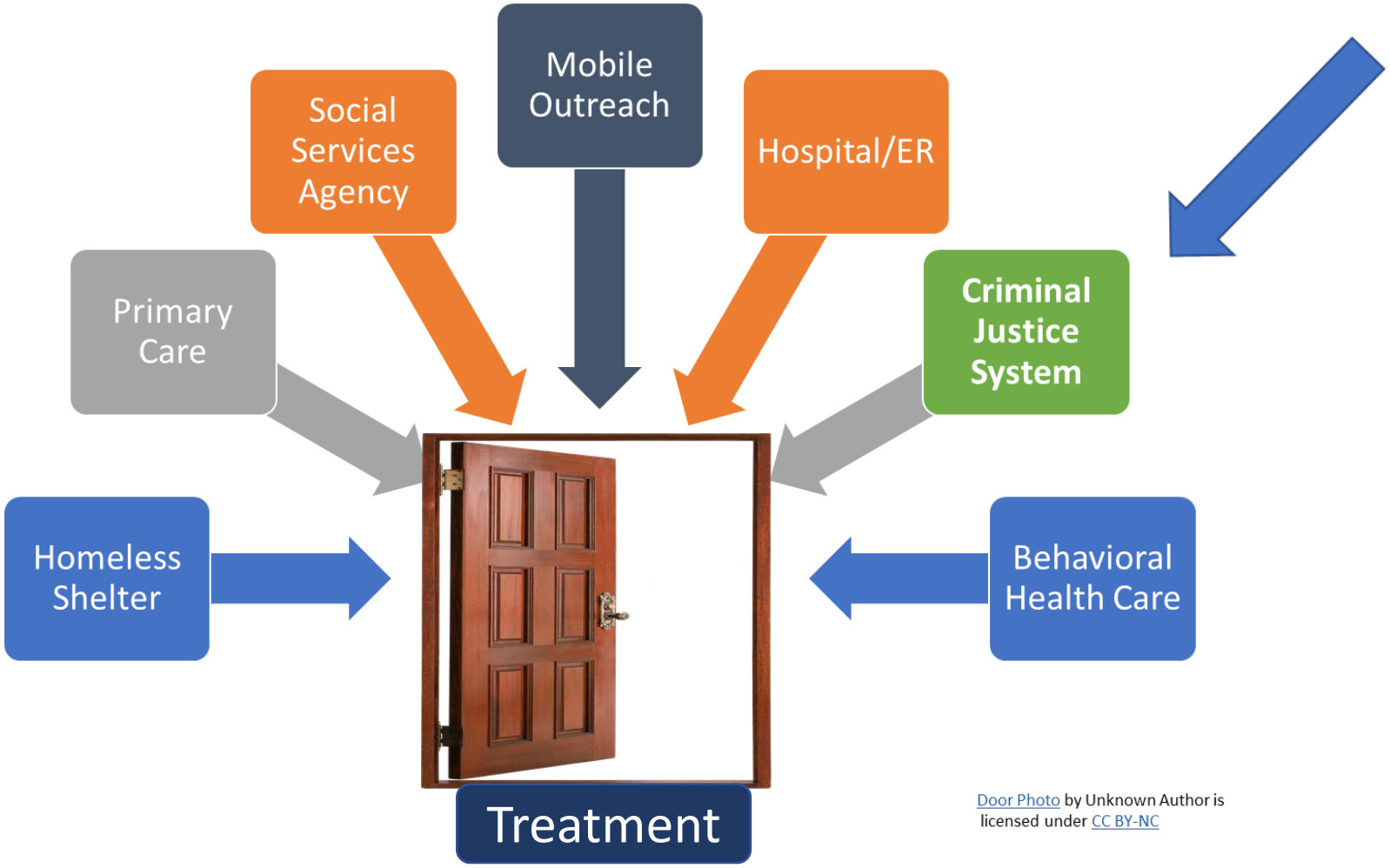
WHY DOES COD THIS HAPPEN?

1. Common risk factors can contribute to both mental illness and substance use disorders.
2. Mental illnesses can contribute to drug use and substance use disorders
3. Substance use and addiction can contribute to the development of mental illness.



TIPS 42: https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses

MANY OPPORTUNITIES TO ENTER TREATMENT



ENTERING TREATMENT THROUGH THE JUSTICE SYSTEM

- Make sure to make referrals/court orders/other that address BOTH THE SUD AND THE MENTAL HEALTH CONDITION
- Do not continue the separation of SUD and mental health treatment
- Integrated dual diagnosis treatment (IDDT) paramount

POST TRAUMATIC STRESS DISORDER

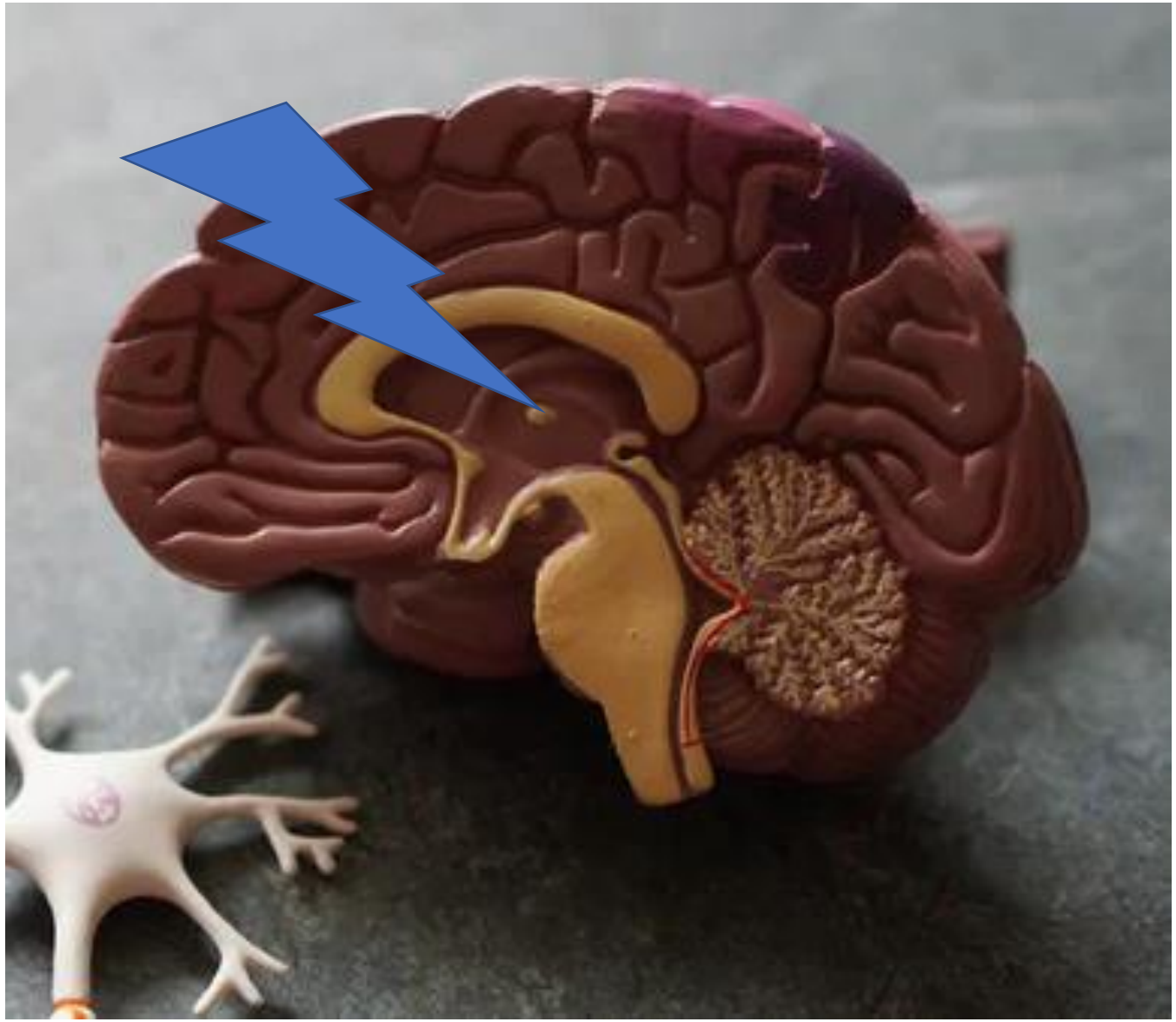
TRAUMA IN JUSTICE-INVOLVED POPULATION

- 50% - 80% of criminal offenders report histories of lifetime traumatic events
  - Sexual abuse, physical abuse, neglect, emotional abuse
  - higher for women – increased incidence sexual violence
  - higher for older inmates who have experienced more trauma while incarcerated
  - trauma increases the incidence of substance use
  - substance use increases the risk of trauma

Journal of Correctional Health 2010

TRAUMA AND THE BRAIN

- Trauma – leads to elevated levels of the stress hormone *cortisol*
- No genetic link
- This can have negative and persistent effects on the body including
  - altered metabolism
  - altered immunity
  - vulnerability for psychiatric disorders
    - depression
    - anxiety
    - PTSD
    - Substance use disorders
    - Personality disorders
  - medical conditions such as
    - cardiovascular disease
    - metabolic disorders
    - cancer



CO-OCCURRING PTSD AND SUD

- The lifetime prevalence of PTSD is 6.5% all populations
- 50% experience co-occurring SUD (typically alcohol use disorder from the study but we know opioid use and polysubstance are issues)
- Comorbidity of PTSD and SUD leads to more legal problems
- Co-occurring PTSD and SUD have negative effects on post incarceration outcomes
  - Women more likely to relapse than men
  - Men more likely to recidivate

2010 National Epidemiologic Survey on Alcohol and Related Conditions

Journal of Correctional Health 2010

TWO FORMS OF MEMORIES

- *Verbally accessible memory* (first recorded in the hippocampus and later in general brain memory storage) can be modified by reflection. This is characteristic of most non-traumatic memories.
- *Situationally accessible memory* is non-verbal and associated with very strong emotions and the amygdala.
- Traumatic memories tend to be stored as *situationally accessible memories*, which are harder to process, are readily triggered by associations, and more likely to cause emotional distress when activated.

Brewin CR, Dalgleish T and Joseph S. A dual representation theory of post-traumatic stress disorder. *Psychological Review*. 1996. 103:670-686.

ACUTE STRESS DISORDER

- First month after a traumatic event – death, injury, violence that happened to you, or witnessed, or heard about
- Lasts at least 3 days and less than a month, includes typical responses to acute trauma
- Symptoms overlap with PTSD and include:
  - *Intrusion symptoms* - memories, dreams, flashbacks
  - *Negative mood* – inability to experience positive emotions
  - *Dissociative symptoms* – altered sense of reality, difficulty remembering event
  - *Avoidance* – to try not to remember distressing event
  - *Arousal* – irritable/angry, hypervigilant, sleep difficulty, startle, reckless behavior
- Resolves in two thirds but if continues can be diagnosed as PTSD

What substances might be used to alleviate these symptoms?

EXACERBATION OF PTSD SYMPTOMS DURING INCARCERATION

- Noise level day and night
- High intensity interactions
- Threats to personal safety
- Overcrowding
- Difficulty sleeping

Screening: PTSD – PCL - 5

This questionnaire asks about problems you may have had after a very stressful experience involving

- actual or threatened death,
- serious injury, or
- sexual violence.

It could be something that happened to

- you directly,
- something you witnessed, or
- something you learned happened to a close family member or close friend.

Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide. (2020: COVID)

Second, below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

TREATMENT OF PTSD

- Prolonged Exposure therapy
- Cognitive Processing Therapy/CBT
- Eye movement desensitization and reprocessing (EMDR)
- Stress inoculation training (SIT)

- Medications
  - Selective serotonin reuptake inhibitors
  - Prazosin – nightmares
- Treat SUD concurrently (motivational interviewing, MAT, 12 step, etc)

INTERACTING WITH INDIVIDUALS WITH TRAUMA AND PTSD

- Limit questioning about details of the trauma and potential to trigger
- Keep a watch out for new traumatic events and develop a plan for increased safety if needed – trauma begets more trauma
- Expect fear, mood swings and irritability – stay neutral and supportive, “how can I help you?”
- Don’t expect a trusting relationship any time soon
- Avoid touch, loud sounds – respect personal space
- Use clear and respectful interactions – if they are reluctant to talk be patient and wait for them to open up – try not to interrupt
- Be aware of your own “compassion fatigue” and the potential to experience “vicarious trauma”

CASE EXAMPLE - JANET

- Janet has checked into treatment for the third time since release. It's been three weeks, and her induction and stabilization on buprenorphine is complete. However, her SUD counselor notices that Janet still appears emotionally flat, seems to be hypervigilant and easily startled, and appears exhausted as a result of vivid dreams that wake her up at night. When she's startled awake her heart is pounding, and she's sweating.
- Janet prefers to spend her free time reading and avoiding the loud teasing and story-telling that the rest of the clients use to bond. If she's honest, the noise makes her want to bite their heads off, which makes her feel bad about herself. It's the same reason she avoids her family when she's home and drinks to "calm down."
- Like many clients in treatment, particularly clients with a multiple relapse history, Janet will continue to struggle with her heroin use unless the treatment team recognizes that she needs to address the symptoms of Post Traumatic Stress and OUD that derail her plans to overcome her addiction.

https://www.mentalhelp.net/ptsd/and-addiction/

POLL/CHAT BOX EXERCISE

POLL

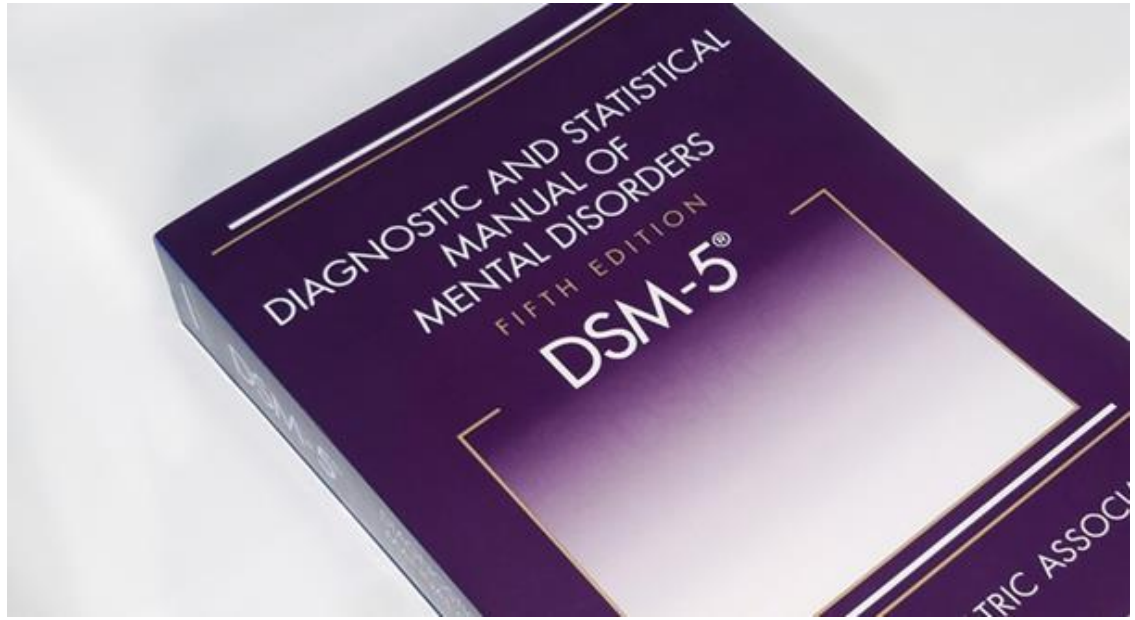
- In your system would you have screened Janet for PTSD?
- Would you have screened her for SUD?
- Would you have screening her for both?
- Would you have screened her for neither?
- Do you have access to IDDT for someone like Janet?

CHAT EXERCISE

If you screen for COD what tool(s) would you use for SUD or PTSD for Janet?

PERSONALITY DISORDERS

PERSONALITY DISORDERS DSM V



- Rigid and unhealthy pattern of thinking, functioning and behaving
- A persistent, inflexible, pervasive pattern of maladaptive traits involving ≥ 2 of the following:
  - cognition (ways or perceiving and interpreting self, others, and events)
  - affectivity
  - interpersonal functioning
  - impulse control
- Significant distress or impaired functioning resulting from the maladaptive pattern
- Relative stability and early onset (traced back to at least adolescence or early adulthood) of the pattern

FACTS

- No genetic link – possible combination of genetic vulnerability and environmental factors during childhood
- 60-90 % of patients with SUD possible Personality Disorders (PD)
- ~ 50% with PD have SUD
- 40-90 % report abuse – sexual, physical, emotional
- Often misdiagnosed as bipolar do
- Presence of PD can lead to higher drop out rates for SUD treatment
- Increased mortality
- Associated with more severe and frequent offending

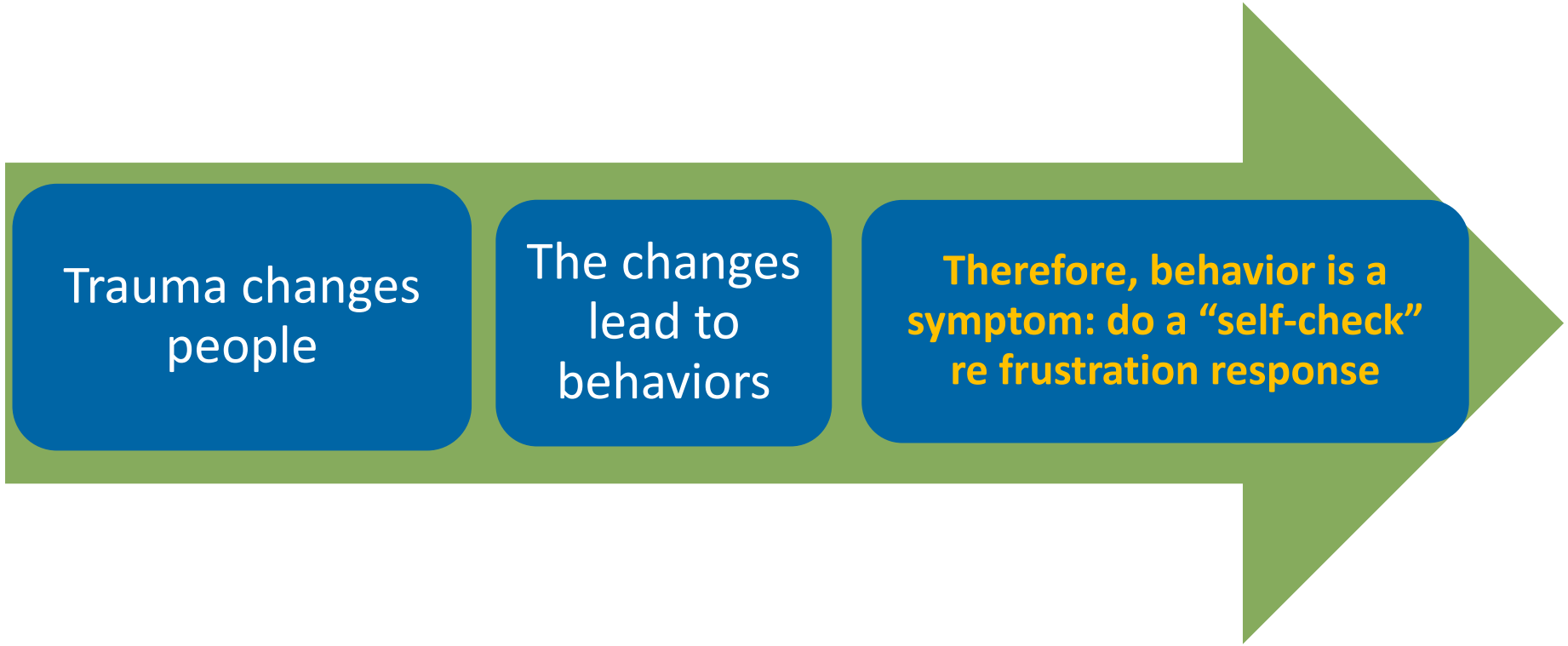
PREVALENCE OF PERSONALITY DISORDERS

- One of the most stigmatized of all conditions
  - “she’s a borderline”
  - “he’s just a psychopath”
  - “they are too difficult to treat so I don’t accept new patients with PDs”
  - “they can’t be helped – nothing works”

- Re-framing
  - These are not intractable disorders – there are evidence-based treatments
  - Stereotypes can be counterproductive and effect counselors’ abilities to treat
  - Self-reflection and peer support or supervision can be helpful with personal feelings regarding working with these clients

SAMHSA TIPS 42

- Awareness; Compassion and Empathy



TYPES OF PERSONALITY DISORDERS

- Cause: childhood maltreatment (typically starts before age 5), genetic component for increased vulnerability, no biological mechanism
- 10 distinct types
  - Cluster A – odd or eccentric thinking
  - *Cluster B – dramatic, overly emotional, unpredictable behavior*
    - *Borderline, antisocial, narcissistic, histrionic*
  - Cluster C – anxious and fearful
- Cluster B more prevalent in corrections settings
  - More likely to have SUD of all personality DO - more compulsive/impulsive behaviors
  - more likely to be arrested if have co-occurring SUD (61%)
  - more likely to have been in prison if have co-occurring SUD (32%)

Subst Abuse. 2014; 8: 17–24

ARRESTED DEVELOPMENT

- a safe, loving, and supportive environment is needed for personality development
- children who were abused or neglected before the age of 5 don’t experience normal early child development
- they remain “stuck” in the developmental stage of a toddler - they steal, lie, argue, throw temper tantrums, blame others for their mistakes, and have trouble regulating their emotions
- they don’t “outgrow” it
- devastating consequences as an adult

What substances might be used to alleviate these symptoms?

Cluster B Disorders: Most Common COD

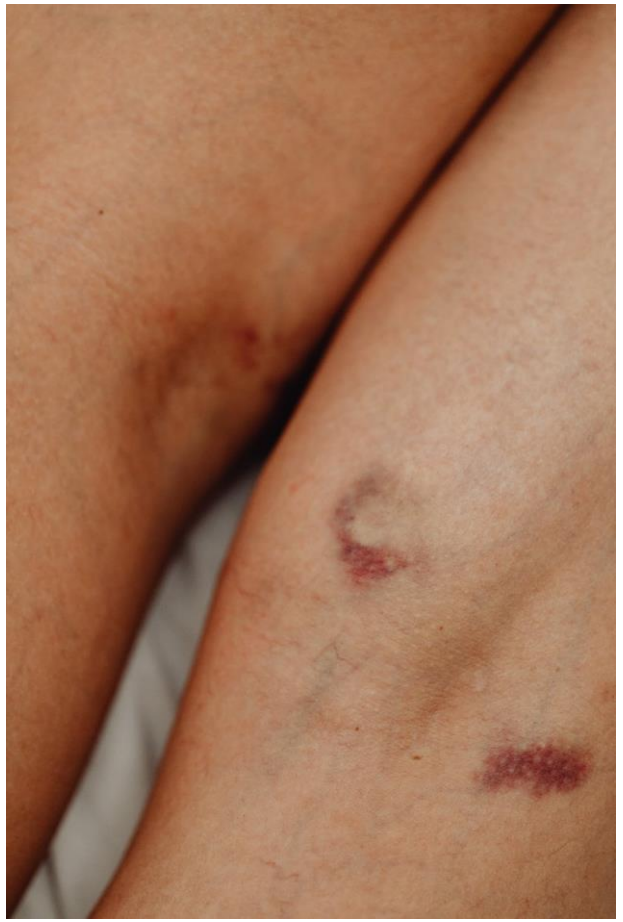
Borderline Personality DO (42% of men and 52% of women)

- **Impulsive and risky behavior**, such as having unsafe sex, gambling or binge drinking
- Unstable or fragile self-image
- Unstable and intense relationships
- Up and down moods, often as a reaction to interpersonal stress
- Suicidal behavior or threats of self-injury
- Intense fear of being alone or abandoned
- Ongoing feelings of emptiness
- Frequent, intense displays of anger
- Stress-related paranoia that comes and goes

Antisocial Personality DO (35% of men and women)

- Disregard for others' needs or feelings
- Persistent lying, stealing, using aliases, conning others
- Recurring problems with the law
- Repeated violation of the rights of others
- Aggressive, often violent behavior
- Disregard for the safety of self or others
- **Impulsive behavior**
- Consistently irresponsible
- Lack of remorse for behavior

SIGNS OF SELF HARM



DIAGNOSTIC TOOLS

- Minnesota Multiphasic Personality Inventory (MMPI)
  - Psychologist administered
  - Time consuming
  - Costly
- Scales for depression and anxiety – PHQ9 or GAD7
- Tools for PTSD – PCL-5
- SUD evaluation tools – NIDA, AUDIT-C, DAST

TREATMENT

- Dialectical behavioral therapy – corrections modified (DBT-CM)
  - Combination of cognitive therapy and mindfulness
  - Develop skills to manage emotions
  - Decreases conflict in relationships
- Medications for mood and anxiety disorders
- Treatment of PTSD and other conditions
- SUD treatment – right level of care

- ** refer for evaluation and not a specific treatment is best

INTERACTING WITH INDIVIDUALS WITH PERSONALITY DISORDERS

- Remain neutral – try not to engage if you feel your own feelings being ignited, distraction or changing the topic may help defuse
- Remember persons with PDs are very sensitive to corrective feedback and can get emotional when it is given – even minor input can cause major emotional reactions – stay neutral but firm
- Forming an alliance is difficult as the focus is primarily on self – it is a slow process and may not occur as hoped
- Be consistent as possible with your behavior. They are not going to change so you need to change the way you interact with them
- Set limits clearly and expectations for proper conduct, document concerns
- Stay civil but do not cross any boundaries - it could come back to hurt you later

CASE EXAMPLE - MARY

- Mary is a 26-year-old African-American woman who was incarcerated for assaulting a peace officer while intoxicated.
- In addition to her drinking, she presents with a history of non-suicidal self-injury, specifically cutting her arms and legs, has made two suicide attempts and reports chronic suicidal ideation, explaining that it gives her relief to think about suicide as a "way out."
- When she is stressed, Mary says that she often "zones out," even in the middle of conversations or while at work. She states, "I don't know who Mary really is," and describes a longstanding pattern of changing her hobbies, style of clothing, jobs and having sex with multiple partners.
- She describes impulsive drinking, often to calm her emotional upheaval
- At times, she thinks that her partner is "the best thing that's ever happened to me" and at other times she admits to thinking "I can't stand him," and will ignore or lash out at him, including yelling or throwing things. Immediately after doing so, she reports feeling regret and panic at the thought of him leaving her.

https://div12.org/case_study/mary-borderline-personality-disorder/

CHAT EXERCISE

Think of the cases that have been presented today and describe in the chat box how in your system you identify both the SUD and mental health conditions

CHAT EXERCISE

What is one thing you are willing to consider doing differently in your system to address co-occurring SUD and mental health conditions?

RESOURCES

- SAMHSA TIPS 42: Substance Use Disorder Treatment for People with Co-occurring Disorders 2020 https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf

- SAMHSA Screening and Assessment for Co-occurring disorders in the Justice System https://store.samhsa.gov/product/Screening-and-Assessment-of-Co-Occurring-Disorders-in-the-Justice-System/PEP19-SCREEN-CODJS

QUESTIONS AND DISCUSSION WITH WEBINAR ATTENDEES

EVALUATION

1. Overall, today's webinar was:
   A. Very useful
   B. Somewhat useful
   C. Not very useful
   D. Not useful at all

2. The material presented today was:
   A. At the right level
   B. Too basic
   C. Too detailed

CONTACT US

LORI RANEY, MD
lraney@healthmanagement.com

HEALTH MANAGEMENT ASSOCIATES

DHCS