



Trauma and substance use: An overlooked comorbidity

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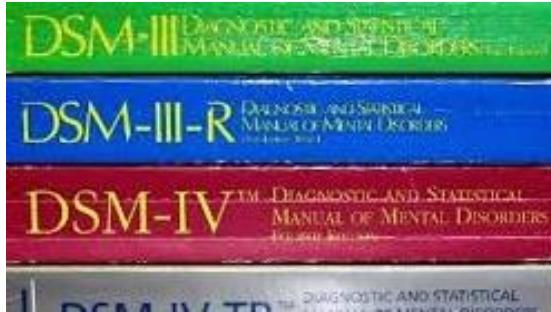
Disclosures

I have no relevant financial relationship with a commercial interest to disclose.

Agenda

- Prevalence of trauma in SUD - special focus on childhood trauma (CT)
- Screening and intervention
- Clinical implications - including but not limited to PTSD
 - Centrality of the therapeutic relationship

History of trauma research



Current understanding of trauma and dissociation is relatively recent

- PTSD new to DSM-III in 1980

Historically, the pendulum swings between recognition and denial of trauma

- Mimics the symptoms of trauma itself
- Social and political movements are needed for trauma to be seen and studied

Mental health, SUD and trauma are usually addressed by separate services systems

- Fragmentation of knowledge

Types of traumatic stressors

1	Accident / disaster / loss	<ul style="list-style-type: none">• Sudden, unexpected, one-time or time-limited• Examples: death, chronic illness, injury, disability, treatment
2	Interpersonal	<ul style="list-style-type: none">• Sudden, unexpected, one-time/time-limited (violence/neglect)• Anticipated, repeated, chronic (betrayal, violation, exploitation)
3	Identity, ethnicity, gender, community	<ul style="list-style-type: none">• Lifelong or episodic destruction, torture, dehumanization
4	Complex	<ul style="list-style-type: none">• Toxic, cumulative exposure to some or all of the above

Trauma among SUD patients

<p>Intimate partner violence Witnessing and direct experience</p>	<p>Rape and sexual assault</p>
<p>Childhood abuse and neglect / ACEs</p>	<p>Military and combat</p>
<p>Sexual exploitation Survival and transactional sex, sex trafficking</p>	<p>Homelessness</p>
<p>Incarceration</p>	<p>Sanctuary trauma</p>

How trauma and substance use intersect

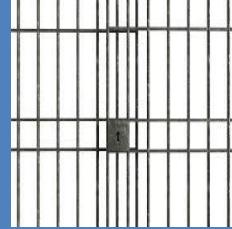
Emerge at same time



SUD pts at higher risk overall



To self-regulate after trauma



Prevalence suggests “universal precautions”

20-90%

Rates of childhood trauma
among SUD patients

25–51%

Prevalence of PTSD among
SUD inpatients

A common comorbidity

- Prevalence of current PTSD 3x higher in SUD patients than general population
- PTSD is particularly prevalent among patients with OUD
 - 14-53% MOUD patients meet criteria for current PTSD
- PTSD is often undiagnosed in SUD patients
- Poorer treatment outcome when PTSD is untreated

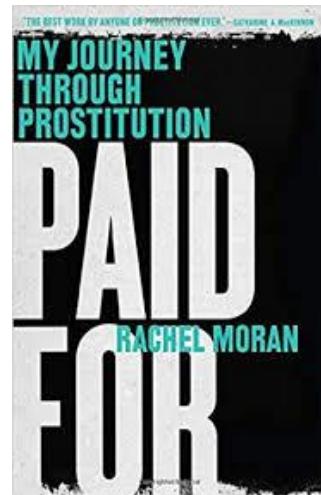
Implications

- CT predicts
 - A younger age of SUD onset
 - More psych symptoms
 - More suicide attempts
 - Earlier drop out from treatment
 - Higher rates of SUD recurrence
 - Polysubstance use
 - Distress independent of PTSD, which predisposes use of substances to “self-medicate”

Carliner et al., 2016; Kang et al., 2002; Mergler et al., 2018; Umut et al., 2017

Dissociation: “A necessary but dangerous thing”¹

“The truth is I learned to operate a certain part of my psyche so that sometimes it didn’t feel like much of anything at all. There is a switch governing the release or restraint of emotion with which most people are unfamiliar because it might have come into play only a limited number of times, sporadically, over the course of their lives. But in prostitution, the use of this on/off function in the governing of emotion is pervasive...It is not lost on the men who buy women in prostitution either. As one of them reported ‘it’s like she’s not really there.’”



“The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based on the empowerment of the survivor and the creation of new connections. Recovery can only take place in the context of relationships; it cannot occur in isolation.”¹



¹Herman, 1992; p.32

The relationship paradox

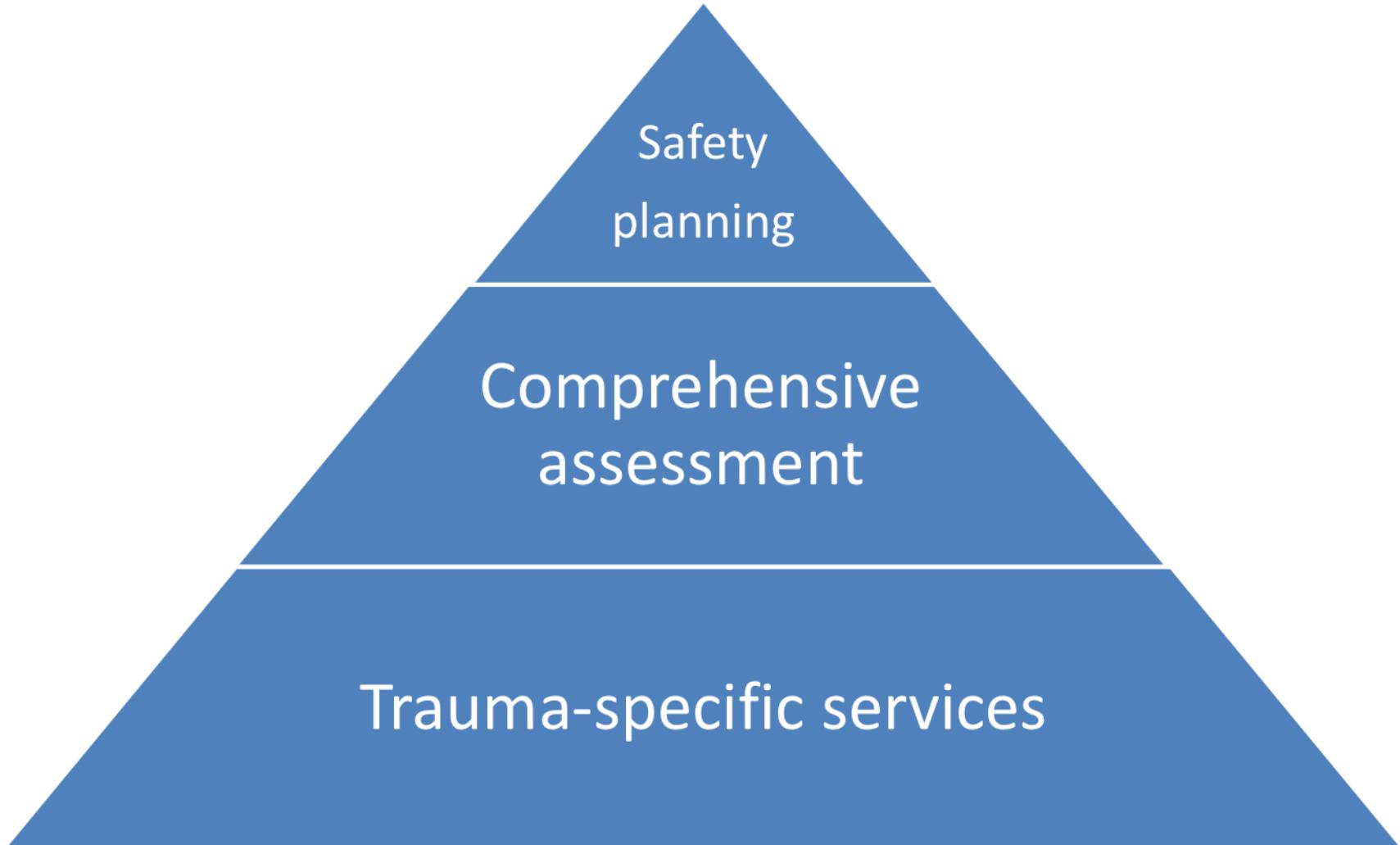
- Expression of emotion – overreaction to minor things and underreaction to danger
 - How patients communicate about needs
- Recreating abuse-related themes in your relationship
- Reenacting trauma themes in relationships
- Your own strong reactions
- Effects on team functioning

Screening

- Purposes
 - Accurate diagnosis and formulation
 - Additional assessment?
 - Impact on functioning and SUD
 - Current safety
- Screening
 - Validated instruments
 - Explain why, give choices
 - Not while intoxicated
 - Procedure for positive screens, esp current risk



Now what?

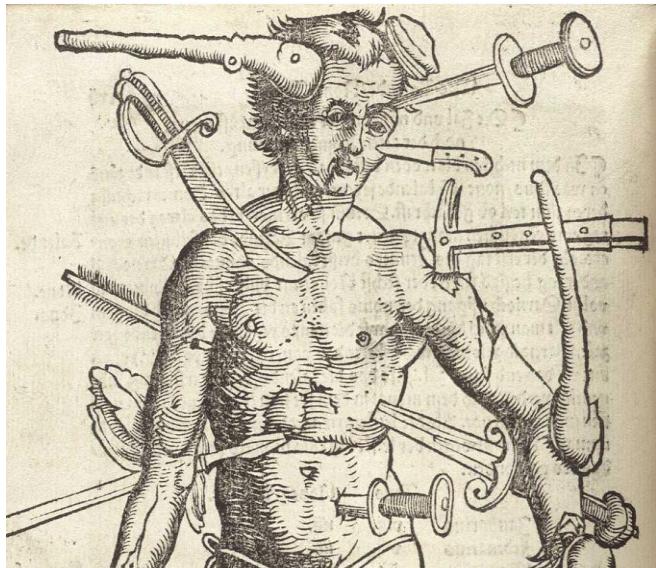


Treatment considerations

- Integrated, trauma-informed care: Addressing SUD and trauma together
- Past vs present focused treatment modalities
 - Targeting PTSD and other impacts: emotional dysregulation; interpersonal problems; risk of revictimization
- When exploitation, violence, trauma is ongoing

Conclusions

- Integrated treatment is considered the gold standard but it is not widely available
- Overlooking the nexus of trauma is a missed opportunity for effective SUD intervention
- Trauma and SUD recovery happen in relationship, which is also an area of great vulnerability and challenge



Thank you

Please keep in touch.
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