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Translating Research into Practice on Alcohol and Polysubstance Use Disorders by Educating the Interprofessional Primary Care Team

Trauma, Substance Use, and Secondary Traumatic Stress

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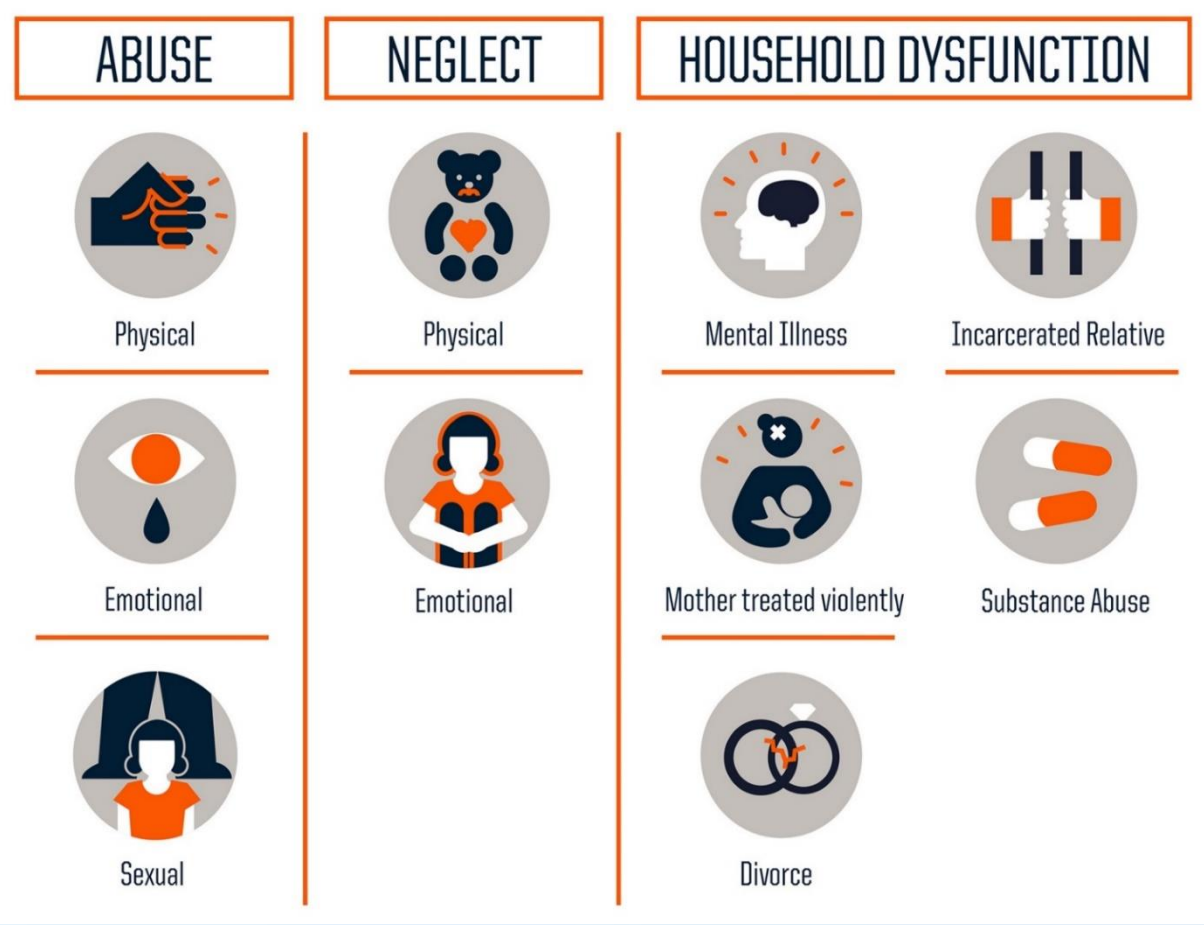
Learning Objectives

- Understand the fundamentals of Adverse Childhood Experiences (ACEs)
- Describe the connection between trauma, alcohol, and other substance use disorders

The ACEs Study

- In 1998 Vincent Felitti and Robert Anda published the first of it's kind ACEs study
- Conducted at Kaiser Health it began as a way to see why patients dropped out of treatment for obesity
- What the ACEs study discovered was a national epidemic of childhood abuse, adversity, and neglect responsible for a myriad of negative health outcomes

What are ACEs?

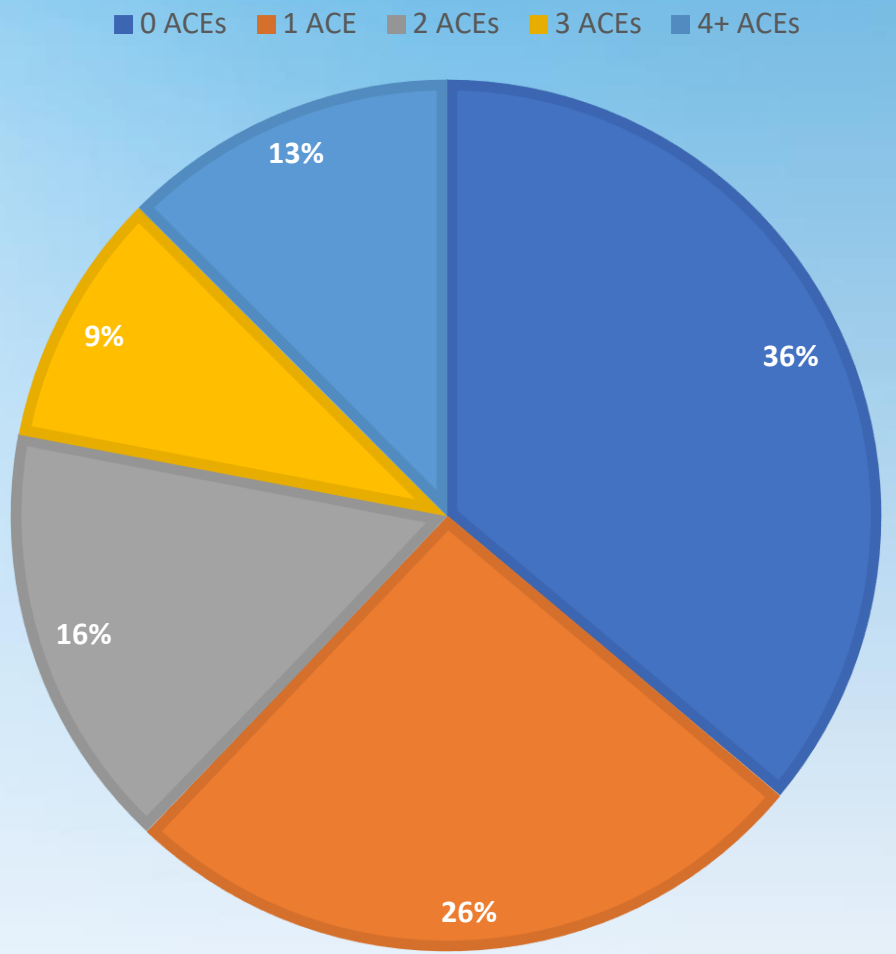


Source: National Public Radio

ACEs Study Findings

- 9508 people participated in the survey
- Predominantly white, middle class, and well educated with 75% of respondents having some college education
- A graded dose-response was observed with health outcomes worsening with more exposure

ACEs Study Findings

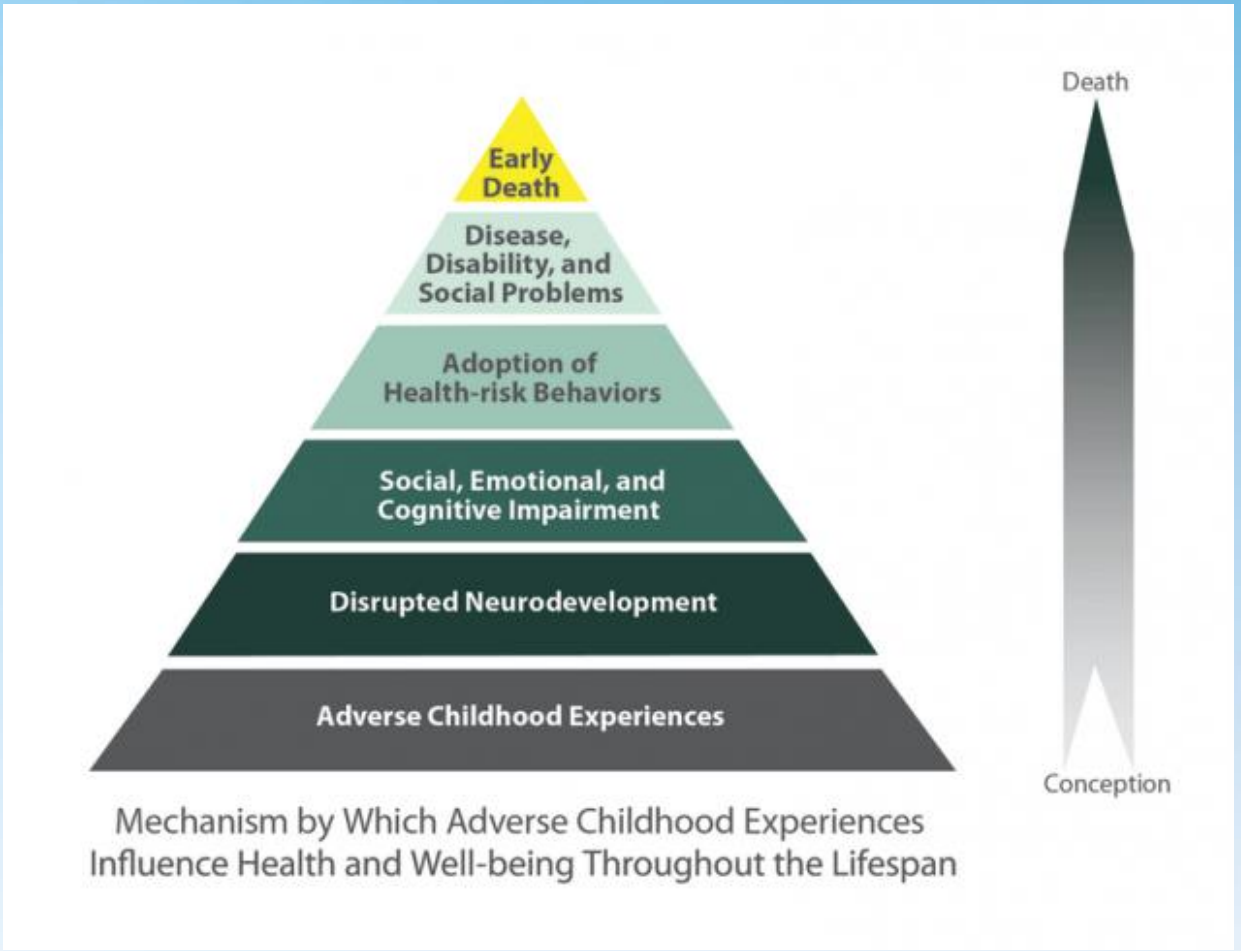


ACEs Study Findings

As ACEs increased so did the prevalence and severity of:

- Alcohol use disorder
- COPD
- Depression
- Drug use
- Ischemic heart disease
- Liver disease
- Sexually transmitted infections
- Smoking
- Suicide attempts
- >50 Sexual partners
- Skeletal fractures
- Cancer
- Obesity
- A sedentary lifestyle

How ACEs Impact Health



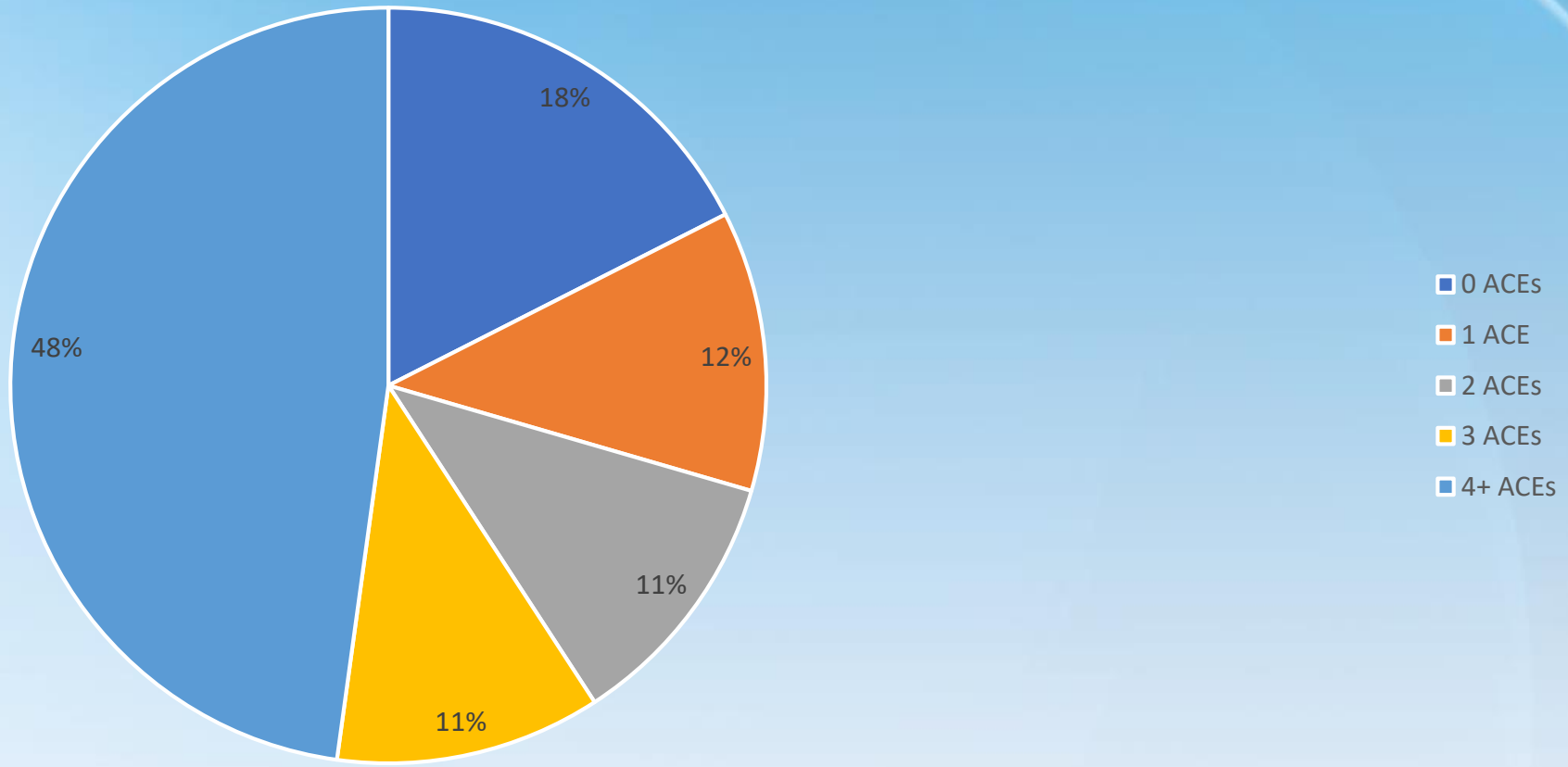
Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Source: CDC

Additional ACEs Data

- Behavioral Risk Factor Surveillance Surveys (BRFSS) have looked at ACEs data on larger scales
- Respondents on TANF in BRFSS have 5 or more ACEs 45% of the time

ACEs at Community Health Center



Source: Bryant, Coman, & Damian, 2020

Trauma & Alcohol Use

What “self-medication” really means

ACEs and Substance Use Disorders

- The ACEs study found people with an ACEs score of 4 or higher were 7.4 times more likely to have an alcohol use disorder and 10.3 times more likely have a history of injection drug use
- Drug use generally was seen in only 6.4% of people with 0 ACEs while 28.4% of those with 4 or more reported using illicit drugs

Adjusted Odds Ratio by ACE

Adjusted Odds Ratios with 95% CI for Specific SUD by Specific Adverse Childhood Experiences with 95% Confidence Intervals.

	Verbal Abuse	Physical Abuse	Sexual Abuse	Emotional Neglect	Physical Neglect	Parental Drug Use	Witnessing DV	Parental MI/Suicide	Parental Incarceration	Parental Divorce
Any SUD	1.41*** [1.23–1.60]	1.51*** [1.32–1.73]	1.47*** [1.27–1.70]	1.32*** [1.15–1.51]	1.45*** [1.23–1.70]	2.07*** [1.81–2.37]	1.36*** [1.18–1.57]	1.28*** [1.12–1.47]	1.42*** [1.21–1.67]	1.30*** [1.14–1.48]
> 1 SUD	1.33*** [1.10–1.59]	1.39*** [1.16–1.68]	1.57*** [1.28–1.93]	1.17 [0.97–1.41]	1.17 [0.92–1.47]	1.90*** [1.57–2.29]	1.31*** [1.08–1.60]	1.16 [0.92–1.31]	1.24 [0.99–1.55]	1.12 [0.93–1.35]
Alcohol Use Disorder	1.18 [0.99–1.40]	1.39*** [1.17–1.65]	1.20 [0.99–1.45]	1.29** [1.08–1.54]	1.31* [1.06–1.62]	1.77*** [1.48–2.10]	1.34** [1.11–1.61]	1.10 [0.92–1.31]	1.10 [0.89–1.35]	1.07 [0.90–1.27]
Cannabis Use Disorder	1.74*** [1.39–2.18]	1.40** [1.12–1.74]	1.62*** [1.28–2.18]	1.50*** [1.20–1.88]	1.42** [1.10–1.84]	1.79*** [1.43–2.24]	1.38** [1.09–1.74]	1.59*** [1.27–1.98]	1.67*** [1.30–2.13]	1.37** [1.09–1.72]
Cocaine Use Disorder	1.38*** [1.08–1.77]	1.51*** [1.18–1.93]	1.67*** [1.28–2.18]	1.24 [0.97–1.60]	1.24 [0.92–1.67]	1.80*** [1.40–2.31]	1.23 [0.94–1.60]	1.08 [0.84–1.39]	1.11 [0.83–1.50]	1.01 [0.79–1.30]
Opioid Use Disorder	1.15 [0.97–1.37]	1.29** [1.09–1.54]	1.32** [1.09–1.59]	1.02 [0.86–1.22]	1.15 [0.93–1.43]	1.65*** [1.40–1.97]	1.14 [0.94–1.37]	1.07 [0.90–1.27]	1.30* [1.06–1.60]	1.17 [0.98–1.39]

Note.
* $p < .05$.
** $p < .01$.
*** $p < .001$.

Source: Bryant, Coman, & Damian, 2020

Alcohol Use and Trauma

- Stress in general, and traumatic stress specifically, increase the risk of:
  - Alcohol seeking
  - Maintenance drinking
  - Relapse
- There are significant sex differences in stressors experienced which means as national stress increases, women are more likely to develop new AUD than men.
- ACEs predict early onset of drinking.
- These predictive experiences also negatively impact neurodevelopment in ways that change reward processing, reduce working memory, and reduce resilient coping – all of which make alcohol and its effects more appealing

Sinha, 2001; Guinle & Sinha, 2020; Rothman et al., 2007; Sinha et al., 2016

The Trauma of Using Substances

- While trauma creates substance use, substance use often creates trauma as well
- Things like
  - Unexpected death of drug using peers
  - Near death experiences and overdose
  - Incarceration
  - Sexual assaults while under the influence
  - Sex work in exchange for drugs
  - Intimate partner violence and its interactions with drug use
- These traumas exacerbate use and compound the trauma

What Does It All Mean?

- If you are treating Alcohol Use Disorder, you **are** treating trauma
- Substance use is one way to get away from the symptoms of trauma and PTSD. Symptoms like
  - Intrusive memories
  - Nightmares
  - Flashbacks
  - Strong reactions to reminders of the trauma
  - Hypervigilance
  - Difficulty sleeping
  - Difficulty concentrating
  - Heightened startle response
- Substance use may be the only relief from these symptoms a person has ever felt
- Nightmares specifically can be reduced by alcohol use due to alcohol's impact on REM sleep

Trauma informed care

Moving from “what’s wrong with you?” to “what happened to you?”

Defining Trauma

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically and/or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, and/or spiritual wellbeing."

Source: SAMSHA

SAMHSA Criteria for TIC

A program, organization, or system that is trauma informed:

1. Realizes the widespread impact of trauma and understands potential paths to recovery
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system
3. Responds by fully integrating knowledge about trauma into practices and
4. Seeks to *actively resist* re-traumatization

Trauma Informed Principles

A trauma informed approach is not prescriptive but rather reflects an adherence to key principles

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

Practical Agency Behaviors

A trauma informed agency

- Assesses everyone for trauma
- Have interventions and resources ready to recommend or refer to for people in need
- Offers support to employees who may have their own trauma or secondary trauma from treating this population
- Offers ongoing training and education to *all* staff because each interaction is a chance to impact someone's trauma

Trauma Informed Primary Care

- The principle of “empowerment, voice, and choice” is vital to practicing trauma informed primary care
- Patients should be engaged in their care by having things explained to them, asking permission when appropriate, and guiding them through practices and procedures
  - Understanding trauma means we recognize this can be as true for sensitive care like a pap-smear as it is for something like taking someone’s weight.
- For alcohol treatment, a menu of options like detox, medication assisted treatment, different ways of taking said medications and more can help engage the patient in their care

Evidenced Based Treatment

- While assessment should be universal, it is okay to refer out for appropriate treatment
- Journaling has an evidence base superior to treatment as usual and without requiring a specialized provider
- The APA recommends Prolonged Exposure therapy, TF-CBT, Cognitive Processing Therapy, and EMDR as evidenced based treatments for PTSD
  - Lisa Najavits' Seeking Safety Model is also an evidence based treatment but is not specifically recommended by the APA
- Clinicians who may have an interest but inadequate training can do harm

Secondary Traumatic Stress

The impacts of the work

Defining STS

- Secondary Traumatic Stress is also often referred to as compassion fatigue, but this is a symptom rather than the same phenomenon
- Charles Figley (1995) defines STS as
  - [T]he natural consequent behaviors resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person.
- Meta-analysis shows enormous correlation between STS and measures of burnout (Cieslak, et al., 2014)
  - These studies show bigger effect sizes in the US healthcare system
  - The direction of this relationship is unclear but it is possible STS leads to burnout *or* that burned out employees are more subject to STS

Symptoms of STS

You might have STS if…

- You feel emotionally avoidant with patients, choosing not to dig too deeply
- You have distressing or intrusive thoughts about the patient's trauma or the patient themselves
- You experience nightmares of the patients' trauma or the patients themselves
- You have difficulty falling asleep or staying asleep
- You have increased alcohol or drug use after work to "de-stress"
- You experience anhedonia
- You have an exaggerated startle response
- You experience hypervigilance for the patient (anxious at missed appointments, etc.)

Many of these symptoms are identical to symptoms of PTSD, the key difference is the cause of and object of the distress.

Preventing STS

- Both individuals and systems have key responsibility in preventing STS
- Individuals can
  - Practice ongoing and dedicated self-care strategies like a spiritual practice, socializing, and regular exercise
  - Monitor your own emotional state and notice when it changes for the negative
  - Journaling
  - Deal with your own trauma in therapy as a high percentage of practitioners working with trauma have some of their own
- Systems can
  - Reduce case loads
  - Provide regular trauma specific supervision
  - Develop team based models where all members can come together to discuss their patients' traumas and the way it impacts them
  - Scheduled debriefings
  - Provide ongoing education around trauma and STS

Treating STSD

- If the symptoms become persistent and last beyond a month, you may have STSD
- The best treatments for STSD are similar to PTSD
  - Journaling
  - Prolonged Exposure therapy
  - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
  - Eye Movement Desensitization and Reprocessing (EMDR)

Questions?

Feel free to unmute or put your questions in the chat!

References

- Bryant, Coman, & Damian, 2020
- Guinle & Sinha, 2020
- Rothman et al., 2007
- Sinha, 2001
- Sinha et al., 2016