

THE HIDDEN HANGOVER: MANAGING ALCOHOL USE DISORDER WITH CO-OCCURRING TRAUMA

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Advancing Pharmacist Roles in Substance Use Disorder Treatment and Recovery Teams ECHO

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- Dr. Frey does not have any relevant financial or other relationships with any ineligible companies or provider(s) of any commercial service(s) discussed in this CE activity.
- This presentation will include discussion of off-label, experimental, and /or investigational use of drugs or devices:
Topiramate, prazosin, desipramine, gabapentin, baclofen, hydroxyzine, trazodone, clonidine.
- Dr. Frey is not an official representative of the Department of Veterans Affairs for this presentation, and the contents do not represent the views of Department of Veterans Affairs or the United States government.

LEARNING OBJECTIVES

1. Evaluate the safety and efficacy of treatment options for co-occurring post-traumatic stress disorder (PTSD) and alcohol use disorder (AUD).
2. Develop a treatment regimen for a patient with co-occurring PTSD and AUD.
3. Describe how trauma-informed care principles can be utilized in patient care interactions.

PREVALENCE AND ASSOCIATIONS

- Life-time prevalence of PTSD estimated at:
 - 3.4 to 8% among US civilians
 - Elevated in subpopulations: women, emergency responders, American Indian/Alaska Natives
 - 7.7 to 13.4% among US Veterans
- 46.4% of persons with PTSD also meet criteria for AUD or another Substance Use Disorder (SUD)
- PTSD + SUD is associated with:
 - Increased suicidality
 - Legal issues
 - Violence
 - Chronic physical health difficulties
 - Reduced social functioning
- Increasing number of traumas is associated with disordered alcohol and substance use
- Interpersonal trauma exposure associated with increased PTSD diagnosis and later AUD or another SUD

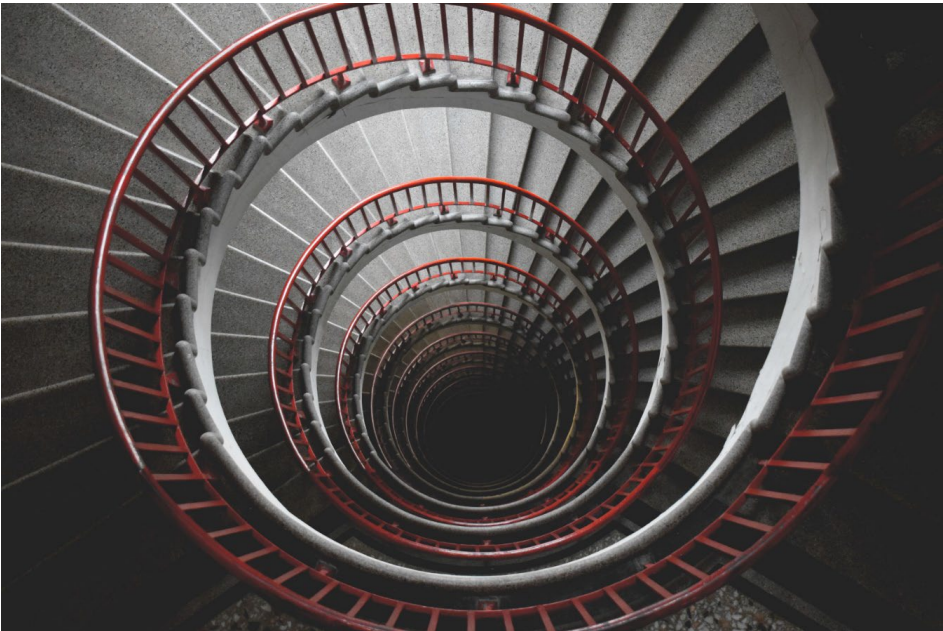
ADVERSE CHILDHOOD EVENTS (ACEs)

- Association between exposure to ACEs and subsequent use of alcohol, cannabis, or other illicit drugs between the ages of 18 and 25 years
- ACEs are strong predictors of externalizing behaviors and poor self-regulation which can lead to use of substances as short-term coping mechanism
- Higher number of traumas in childhood is associated with a greater lifetime risk of developing AUD



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WHERE DOES IT START: PTSD OR AUD?



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- PTSD first:
 - “self-medication hypothesis”: alcohol used to numb symptoms
- AUD first:
 - SUD use increases risk of exposure to traumatic events
 - “susceptibility model”: use inhibits trauma processing and worsens PTSD symptoms
- Mutual maintenance model: alcohol temporarily targets PTSD symptoms, but ultimately maintains/worsens symptoms as it inhibits trauma processing

Smith DNL; Cottler LB. The epidemiology of PTSD and AUD. *Alcohol Research: Current Reviews*. 2018; 39 (2):113-120.

Tripp JC et al. Bidirectional relationship of PTSD symptom severity and alcohol use over the course of integrated treatment. *Psychol Addict Behav*. 2020 June; 34(4): 506–511.

DSM-5 AUD CRITERIA

3 C's	2+ of the following in 12-month period	
Control	Greater substance use than intended	Mild (2-3)
	Unsuccessful attempts/desire to cut down	
	Great deal of time	
Consequences	Role failure: work, school, home	Moderate (4-5)
	Continued use despite social/interpersonal problems	
	Important activities given up because of use	Severe (6+)
	Recurrent use in physically hazardous situations	
	Use despite knowledge of worsening physical or psychological problem	
Cravings	Cravings/desire/urge	
	Tolerance	
	Withdrawal	

DSM-5 CRITERIA: PTSD

A: Trauma Exposure	Exposure to actual or threatened death, serious injury, or sexual violence
B/C/D/E	Meeting the threshold of each clinical category (see next slide)
F/G/H	-Duration >1 month -Clinically significant distress/impairment -Not attributable to physiological effects of a substance or another medical condition

DSM-5 CRITERIA: PTSD

B- Intrusion (1+)

Intrusive distressing memories
Distressing dreams
Dissociative reactions
Psychological distress
Physiological distress

Avoid distressing memories, thoughts, or feelings
Avoid external reminders

C-Avoidance (1+)

D- Negative alterations in cognitions and mood (2+)

Inability to remember important trauma aspect
Exaggerated negative beliefs
Distorted cognitions
Persistent negative emotional state
Diminished interest
Feelings of detachment/estrangement
Inability to experience positive emotions

Irritability/anger
Reckless/self-destructive behavior
Hypervigilance
Exaggerated startle
Concentration challenges

E- Arousal (2+)

PATIENT CASE

- “Arnie” is a male in his 60s with history of:
- DSM-5 Diagnosis:
 - PTSD, moderate, chronic (sexual trauma as a teen; military related trauma)
 - Functional Neurological Disorder
 - Major Depressive Disorder, mild, recurrent
 - Alcohol Use Disorder
- Other pertinent medical conditions:
 - COPD
 - Thoracic Aortic Aneurysm
 - Spinal Stenosis
 - Benign Prostatic Hypertrophy
- Referred for medications for AUD (M-AUD)

PATIENT CASE- SOCIAL HX AND PERSONAL GOALS

- Social: retired-worked in construction, vocational degree in welding, divorced, lives alone in own home, engaged in older adult exercise group, chronic family discord
- What matters to this person?
 - Wants to feel better physically
 - Working on continued weight loss
 - Fishing, woodworking
- Substance use:
 - Four "4 finger drinks" per day estimates 3-4 shots of brandy per drink (up to 16 per day)
 - Veteran's goal is reduced use
 - Stopped all forms of cannabis: had previously moved from smoking to gummies as a form of harm reduction
 - Stopped tobacco (cigarettes) 2+ years ago
 - Denies other substance use

PATIENT CASE- PERTINENT LABS & VITALS

Test name	Result	units	Ref. range
SODIUM	139	mmol/L	136 - 145
POTASSIUM	4.1	mmol/L	3.5 - 4.7
CHLORIDE	104	mmol/L	98 - 109
CO2	27	mmol/L	21.0 - 32.0
UREA NITROGEN	10	mg/dL	7 - 21
CREATININE	0.78	mg/dL	0.73 - 1.18
GLUCOSE	106 H	mg/dL	70 - 99
CALCIUM	9.5	mg/dL	8.7 - 10.4
eGFR	98	mL/min	≥ 60
ANION GAP (MODIFIED)	8	mmol/L	5 - 15

Test name	Result	units	Ref. range
TSH	2.942	uIU/mL	0.550 - 4.780
TOT. BILIRUBIN	0.8	mg/dL	0.2 - 1.2
ALBUMIN	4.2	g/dL	3.4 - 5.0
AST/SGOT	24	U/L	10 - 37
ALKALINE PHOSPHATASE	88	U/L	45 - 117
ALT/SGPT	28	U/L	10 - 65

Vitals	
BP: 127/80 mmHg	pulse 104 bpm
Weight: 309 lbs	BMI: 42 kg/m ²

PATIENT CASE- MEDICATIONS

Current medications:

- Gabapentin 600mg TID for AUD
- Nicotine mini lozenge 4mg PRN
- Prazosin 2mg QAM and 2mg QHS for nightmares
- Trazodone 50-100mg QHS for sleep
- Albuterol PRN shortness of breath
- Fluticasone 250mcg/salmeterol 50mcg BID for COPD
- Lovastatin 40mg QHS for cholesterol
- Tamsulosin 0.8mg QPM for enlarged prostate

Past trials of meds for AUD:

- Naltrexone oral 25mg daily X1 week, then 50mg daily

AUD TREATMENT GUIDELINES

VETERAN AFFAIRS DEPARTMENT OF DEFENSE (VA DOD) SUD GUIDELINES 2021

Pharmacotherapy for AUD

Recommended (STRONG)	naltrexone, topiramate
Suggested (WEAK)	acamprosate, disulfiram
Recommended as second line (WEAK)	gabapentin

PTSD+AUD Meds Commentary:

Topiramate:

- Recommended because of the moderate quality evidence for a significant reduction in heavy drinking and promotion of abstinence

Prazosin:

- Highlighted Randomized Controlled Trial (RCT) by Simpson et al. which evaluated prazosin in individuals with AUD but without PTSD with benefit

Simpson TL et al. *Am J Psychiatry*. 2018; 2018 Dec 1;175(12):1216-1224

VA DoD SUD Guidelines 2021: <https://www.healthquality.va.gov/guidelines/MH/sud/>

RELEVANT CLINICAL GUIDELINES: PSYCHOTHERAPY FOR AUD

Behavioral Couples Therapy

- Effective for Veterans and their partners
- Focus on reducing alcohol use and improving marital satisfaction

Cognitive Behavioral Therapy

- Teaches modification of thinking and behavior related to SUD use or other life areas functionally related to SUD use

Community Reinforcement Approach

- Comprehensive cognitive-behavioral intervention that focuses on environmental contingencies that impact and influence behavior
- Uses family, social, recreational and occupational events

12-Step Facilitation

- Aims to increase active involvement in AA or other 12-step based mutual help group
- 12- step involvement is instrumental in explaining benefit of this therapy

Motivational Enhancement Therapy

- Uses Motivational Interviewing in a more structured approach
- Highlights ambivalence and promotes change
- Some evidence for AUD and low readiness or high anger

AA: Alcoholics Anonymous

VA DOD SUD Guidelines 2021: <https://www.healthquality.va.gov/guidelines/MH/sud/>

ACCESS TO EVIDENCE-BASED CARE

“Use of a substance should not automatically preclude provision/continuation of treatment for a co-occurring condition. Rather, adjustments to treatment should be made consistent with existing clinical practice guidelines, if indicated, with a focus on **concurrent treatment for both concerns.**”

“Best to provide **integrated care for all conditions** in a single setting when possible, and if not, SUD should be **managed collaboratively.**”

Patient case question

Given what we have learned so far about AUD guidelines and this patient case, which of the following would you recommend as next option for targeting AUD?

- A. Naltrexone oral or injectable
- B. Topiramate
- C. Acamprosate
- D. Disulfiram
- E. Gabapentin

MEDICATIONS FOR AUD

MEDICATION MONITORING AND PEARLS: NALTREXONE

FDA Approved

Contraindications	Monitoring	Typical Dosing	Adverse Effects	Patient Education
-Opioid use within last 7-10 days (longer with longer acting opioids) -Acute hepatitis or severe hepatic impairment -Inadequate muscle mass (IM only)	Baseline: -LFTs -Urine beta-HCG (for females) -Urine drug screen Follow-up: -LFTs at 6 and 12 months; then annually Discontinue if there is no detectable benefit within 3 months	-50 mg orally daily -380 mg every four weeks or monthly as a gluteal injection	Common: Nausea, injection site reaction (IM only) Other: Headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, somnolence Eosinophilic pneumonia, depression, suicidality (all IM only)	-Wallet card (or medical ID bracelet/pendant) -Signs/sx of hepatic toxicity -Interaction with medications with opioid properties

LFTs: Liver function tests; IM: Intramuscular; HCG: Human Chorionic Gonadotropin; FDA: US Food and Drug Administration
For more detailed info: [VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders Provider Summary](#)
PCSS Clinical Tool: [Monitoring of Liver Function Tests in Patients Receiving Naltrexone or Extended-Release Naltrexone](#)

MEDICATION MONITORING AND PEARLS: TOPIRAMATE

Contraindication	Monitoring	Typical Dosing	Adverse Effects	Patient Education
-Avoid alcohol within 6 hours of topiramate XR -Caution in cognitive dysfunction -Caution in pregnancy: can cause cleft lip and/or palate	Baseline: -Renal function -Serum bicarbonate -Urine beta-HCG (for females) Follow-up: -Periodic renal function (more often if renal dysfunction or advanced age) -Mood/Suicidality -Discontinue after 3 month of adequate dose if no response	-Titrate gradually over several weeks to minimize side effects -Initiate at 50 mg/day; maximum dose of 100 mg twice daily -CrCl <70 mL/min: Administer 50% dose and titrate more slowly	-Paresthesia, nervousness, fatigue, ataxia, drowsiness, lack of concentration, memory impairment, confusion -Abdominal pain, anorexia -Weight loss -Acute myopia/ secondary angle closure glaucoma -Increased SI (epileptic agent class warning) -Metabolic acidosis -Oligohydrosis and hyperthermia	-Topiramate may decrease the serum concentrations of contraceptives and decrease effectiveness -Need to titrate slowly to reduce risk for cognitive effects -Caution in task requiring mental alertness -Taper if stopping -Weight loss may occur -Not FDA approved for AUD but effective

CrCl: Creatinine Clearance; SI: Suicidal ideation

For more detailed info: [VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders Provider Summary](#)

MEDICATION MONITORING AND PEARLS: ACAMPROSATE

FDA Approved

Contraindications	Monitoring	Typical Dosing	Adverse Effects	Patient Education
Severe renal insufficiency (CrCl $\leq$ 30 mL/min)	Baseline: -Renal function -Urine beta-HCG (for females) Follow-up -Renal function (more often if renal dysfunction or advanced age) -Mental status/suicidality	-666 mg orally three times daily -CrCl 30 – 50 mL/min: reduce to 333 mg three times daily	-Major: Suicidality 2.4% (vs. 0.8% on placebo during the first year in clinical trials) -Common: Diarrhea (16%) -Other: Anxiety, asthenia, depression, insomnia	-Report any new or worsening depression or suicidal thinking -Food may decrease bioavailability -Do not double the doses if earlier doses are missed -More beneficial for maintaining abstinence than reducing use

For more detailed info:

[VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders Provider Summary](#)

MEDICATION MONITORING AND PEARLS: DISULFIRAM

FDA Approved

Contraindications	Monitoring	Typical Dosing	Adverse Effects	Patient Education
-Patient lacks ability to provide informed consent -Severe cardiac disease or CAD -Severe hepatic dysfunction (LFTs>3x upper limit of normal or abnormal bilirubin) -Psychosis -Use of metronidazole, paraldehyde, alcohol, or alcohol containing preparations	Baseline: -Abstinence >12 hours and BAL=0 (verify with BAL or breathalyzer) -LFTs -CBC and BMP -Physical assessment -Psychiatric assessment -ECG if indicated -Urine beta-HCG (for females) Follow-up: -LFTS within 1-month, monthly X3 months, then periodically -Consider discontinuation in event of relapse or when patient is not available for supervision and counseling	250 – 500 mg orally once daily for 1 – 2 weeks, then maintenance treatment is 250 mg orally once daily (range: 125 – 500 mg daily) Alternate: -Reduce dose to 125 mg to reduce side effects -For monitored administration, consider giving 500 mg on MWF	-Major: Hepatotoxicity, peripheral neuropathy, psychosis, delirium, severe disulfiram-ethanol reaction -Common: Somnolence, metallic taste, headache	-More effective with monitored administration (e.g., in clinic, with spouse, with probation officer). Should not be given without patient's awareness -Avoid alcohol in all forms (e.g., mouthwash, OTC medications) -Counsel patient to report immediately if fatigue, abdominal pain, fever, nausea, jaundice or clay- colored stools occur -Wallet card or medical ID rec. -Caution in task requiring mental alertness

BAL: Blood alcohol level; BMP: Basic metabolic panel; CAD: Coronary artery disease; CBC: Complete blood count; ECG: electrocardiograph LFTs: Liver function tests

For more detailed info:

[VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders Provider Summary](#)

MEDICATION MONITORING AND PEARLS: GABAPENTIN

Contraindications	Monitoring	Typical Dosing	Adverse Effects	Patient Education
Caution for use during pregnancy: may result in higher risk of preterm birth, NICU admission, and SGA	Baseline: -CrCl (estimated or measured) -Urine beta-HCG for females Follow-up: -Renal function (more often if renal dysfunction or advanced age) -Mood/suicidality -Monitor quantities prescribed and usage patterns -Discontinue if no benefit with at least 900 mg daily for 2 – 3 months	-Titrate up gradually to minimize side effects -Initiate at 300 mg on day one and increase by 300 mg daily as tolerated to target of 1,800 mg/day administered in three divided doses -Renally adjust dose when CrCL<60mL/min	-Dizziness, drowsiness, ataxia, fatigue, peripheral edema -Diarrhea, nausea/vomiting, abdominal pain -Misuse potential at supratherapeutic doses -Respiratory depression with concomitant CNS depressants	-Take first dose on first day at bedtime to minimize somnolence and dizziness -Caution performing tasks requiring mental alertness -Antacids may decrease levels of gabapentin

SGA: Small for gestational age

[2019 FDA Drug Safety Communication: FDA warns about serious breathing problems with seizure and nerve pain medicines gabapentin and pregabalin](#)

For more detailed info: [VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders Provider Summary](#)

LIVER DYSFUNCTION AND MEDICATIONS FOR AUD

Study	Participants/Setting	Exposure	Findings
Vannier et al. (2022)	n= 9635 patients with AUD Retrospective, cohort study Mean follow-up duration: 9.2 years	Medication for AUD: -disulfiram -acamprosate -naltrexone -gabapentin -topiramate -baclofen	M-AUD associated with: • ↓ incidence ALD (aOR, 0.37; 95% CI, 0.31-0.43; $P < .001$) • ↓ incidence of hepatic decompensation in cirrhosis (aOR, 0.35; 95% CI, 0.23-0.53, $P < .001$)

LIVER DYSFUNCTION AND MEDICATIONS FOR AUD

Table 2. Odds Ratios for the Development of Alcohol-Associated Liver Disease After Medical Addiction Therapy

Medical addiction therapy	Adjusted odds ratio (95% CI)	P value
Any pharmacotherapy	0.37 (0.31-0.43)	<.001
Gabapentin	0.36 (0.30-0.43)	<.001
Topiramate	0.47 (0.32-0.66)	<.001
Baclofen	0.57 (0.36-0.88)	.01
Naltrexone	0.67 (0.46-0.95)	.03
Disulfiram	0.86 (0.43-1.61)	.66
Acamprosate	2.59 (1.84-3.61)	<.001

LIVER DYSFUNCTION AND MEDICATIONS FOR AUD

Table 3. Odds Ratios for Developing Hepatic Decompensation After Medical Addiction Therapy

Medical addiction therapy	Adjusted odds ratio (95% CI)	P value
Any pharmacotherapy	0.35 (0.23-0.53)	<.001
Naltrexone	0.27 (0.10-0.64)	.005
Gabapentin	0.36 (0.23-0.56)	<.001
Topiramate	0.43 (0.17-0.99)	.05
Baclofen	1.06 (0.39-2.69)	.91
Acamprosate	1.99 (0.99-4.059)	.06
Disulfiram	2.59 (0.54-13.26)	.24

WITHDRAWAL MANAGEMENT & LEVEL OF CARE

Risk Factors for Severe or Complicated Withdrawal

- Hx of delirium tremens or alcohol withdrawal seizure
- Numerous prior withdrawal episodes
- Co-occurring medical or surgical illness [especially Traumatic Brain Injury (TBI)]
- Age >65 years
- Long duration of heavy/regular alcohol consumption
- Marked autonomic hyperactivity on presentation
- Benzodiazepine or barbiturate use
- Other substance use or SUD
- Positive blood alcohol in presence of withdrawal sx
- Co-occurring psychiatric disorder

Withdrawal Assessment Tools:

- Prediction of Alcohol Withdrawal Severity Scale (PAWSS)
- Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar)

ASAM Practice Guideline on Alcohol Withdrawal Management 2020 available at: https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/quality-science/the_asam_clinical_practice_guideline_on_alcohol-1.pdf?sfvrsn=ba255c2_0

PAWSS available at: <https://www.mdcalc.com/calc/10102/prediction-alcohol-withdrawal-severity-scale>

CIWA-Ar available at: <https://www.mdcalc.com/calc/1736/ciwa-ar-alcohol-withdrawal>

PREDICTION OF ALCOHOL WITHDRAWAL SEVERITY SCALE (PAWSS)

Ask the patient:	Points	
Have you been recently intoxicated or drunk within the last 30 days?	No	0
	Yes	1
Have you ever experienced previous episodes of alcohol withdrawal?	No	0
	Yes	1
Have you ever experienced withdrawal seizures?	No	0
	Yes	1
Have you ever experienced delirium tremens (DTs)?	No	0
	Yes	1
Have you ever undergone alcohol rehabilitation treatment (i.e., inpatient or outpatient treatment programs, or Alcoholics Anonymous attendance)?	No	0
	Yes	1
Have you ever experienced blackouts?	No	0
	Yes	1
Have you combined alcohol with other “downers” (e.g. benzodiazepines, barbiturates) during the last 90 days?	No	0
	Yes	1
Have you combined alcohol with any other substance of abuse during the last 90 days?	No	0
	Yes	1

Clinical evidence:	Points	
Positive blood alcohol level (BAL) on presentation	No	0
	Yes	1
Evidence of increased autonomic activity (i.e., HR >120, tremor, sweating, agitation, nausea)?	No	0
	Yes	1

Score Interpretation		
PAWSS Score	Risk of complicated AWS	Likelihood ratio
<4	Average	0.07
≥4	High	174
Complicated Alcohol Withdrawal Syndrome (AWS) Withdrawal hallucinosis, withdrawal-related seizures, or delirium tremens.		

PTSD TREATMENT GUIDELINES

VA DOD PTSD & ACUTE STRESS DISORDER GUIDELINES 2023

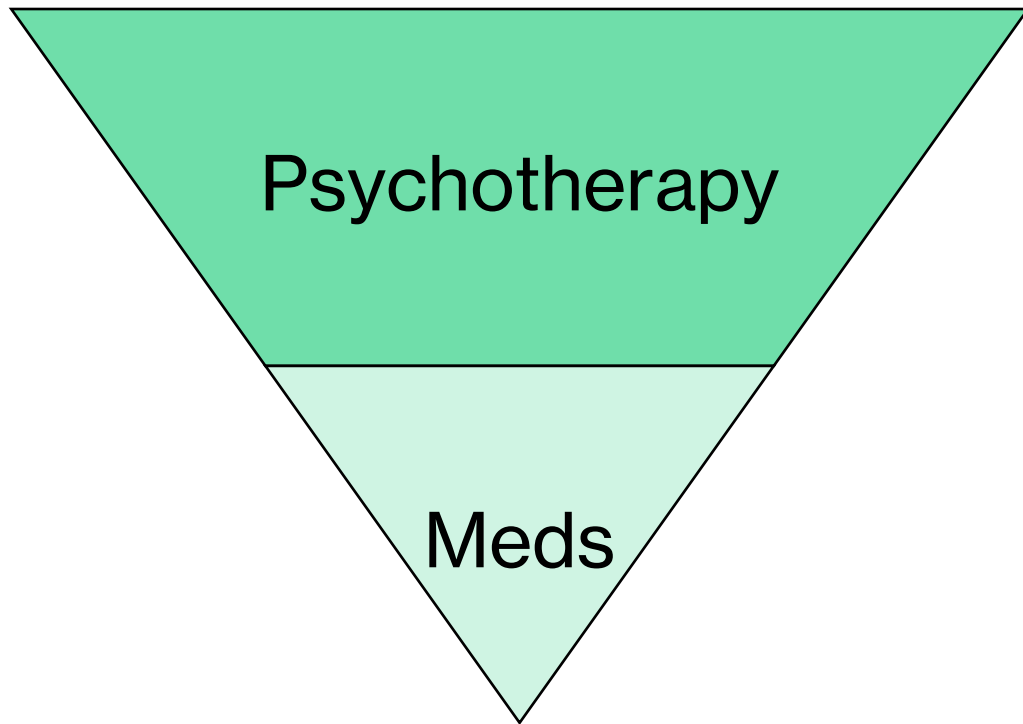
Pharmacotherapy for PTSD	
Strong FOR	• Paroxetine*, sertraline*, or venlafaxine
Neither for nor against	• Amitriptyline, bupropion, buspirone, citalopram, desvenlafaxine, duloxetine, escitalopram, eszopiclone, fluoxetine, imipramine, mirtazapine, lamotrigine, nefazodone, olanzapine, phenelzine, pregabalin, rivastigmine, topiramate, or quetiapine • Psilocybin, ayahuasca, dimethyltryptamine (DMT), ibogaine, or lysergic acid diethylamide (LSD)
Weak AGAINST	• Divalproex, guanfacine, ketamine, prazosin^, risperidone, tiagabine, or vortioxetine
Strong AGAINST	• Benzodiazepines • Cannabis or cannabis derivatives

^prazosin as monotherapy (Weak FOR prazosin for PTSD nightmares)

*FDA approved for PTSD

VA DoD PTSD Guidelines 2023: <https://www.healthquality.va.gov/HEALTHQUALITY/guidelines/MH/ptsd/>

VA DOD PTSD & ACUTE STRESS DISORDER GUIDELINES 2023



General Recommendations:

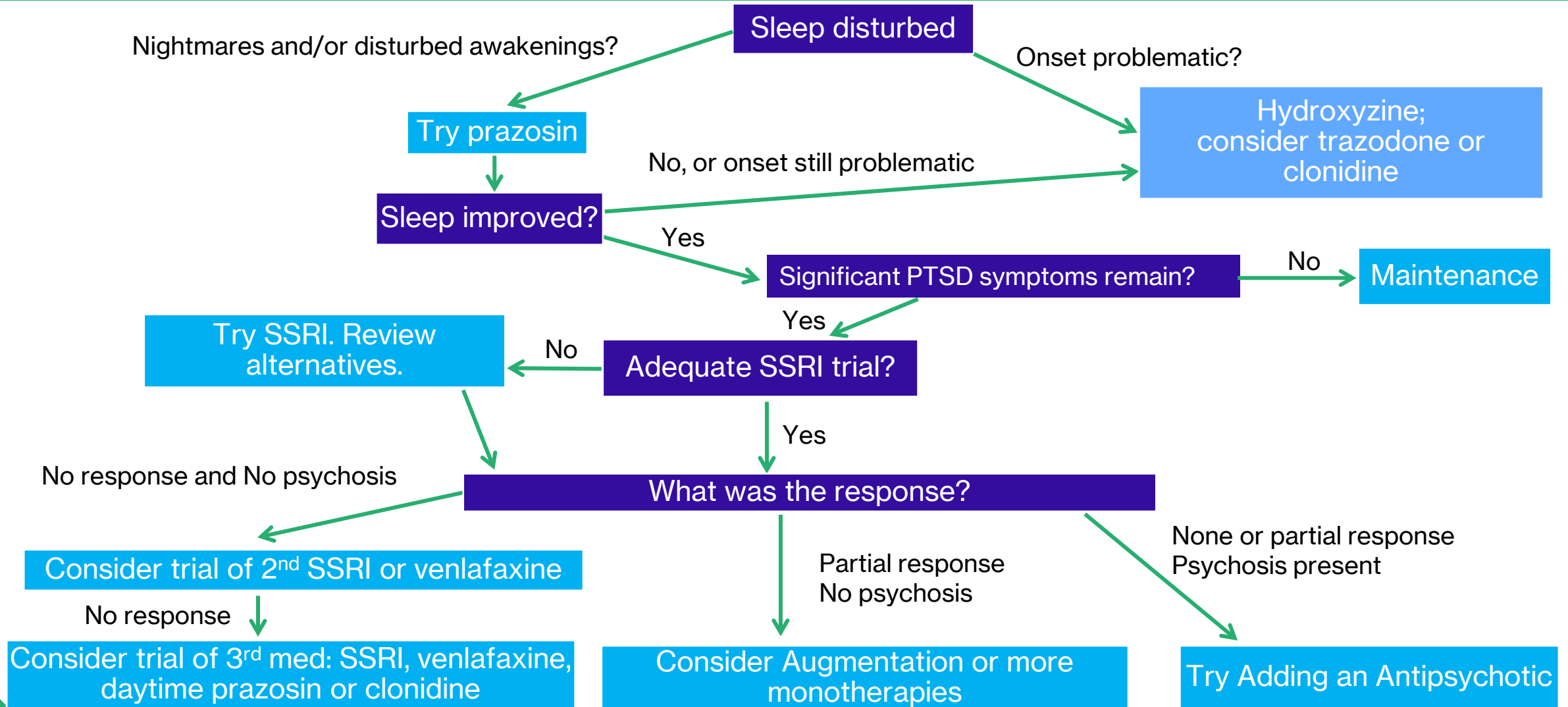
- Cognitive Processing Therapy (CPT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Prolonged Exposure (PE)

Co-Occurring PTSD/SUD:

- Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE)

“Presence of an SUD should not prevent treatment with evidence-based, trauma-focused therapy for PTSD”

2022 HARVARD TREATMENT ALGORITHM: PTSD



HARVARD TREATMENT ALGORITHM: PTSD CONTINUED

SUD Population Commentary:

- Screen for SUD use
- Recommend 1 week abstinence prior to using algorithm
- Avoid Benzodiazepines
- Mixed evidence for prazosin in PTSD/AUD population; 2025 commentary update affirmed support for prazosin use
- Desipramine has one positive study in PTSD/AUD population
- Topiramate has positive outcomes in Veterans with PTSD/AUD for cravings, use, and PTSD symptoms (esp. hyperarousal)

Patient case question

Given what we have learned so far about PTSD guidelines and the patient case scenario previously described, which of the following would you consider for targeting PTSD symptoms for “Arnie”?

- A. SSRI or SNRI
- B. Vortioxetine
- C. Cannabis
- D. Topiramate
- E. Desipramine

TRAUMA-INFORMED CARE

TRAUMA-INFORMED CARE PRINCIPLES

Safety

Peer Support

**Trustworthiness
& Transparency**

**Collaboration
and Mutuality**

**Empowerment,
Voice & Choice**

**Cultural,
Historical, &
Gender Issues**

SOCIOCULTURAL FACTORS



Religion & Spirituality

Language & Styles of Communication

Geographic Location

Worldview, Values, & Traditions

Family & Kinship

Gender Roles & Sexuality

Socio-Economic Status & Education

Immigration & Migration History & Patterns

Cultural Identity & Degree of Acculturation

Heritage and History

Perspectives on Health, Illness & Healing Practices

TRAUMA-INFORMED CARE: PEARLS IN PRACTICE

- Learn about individual cues/triggers
- Be supportive, empathetic, & collaborative
- Encourage sharing about needs/preferences
 - From the treatment options described, which seem to match your present concerns and needs?
 - From your experience, what responses from others appear to work best when you feel overwhelmed by your emotions?
- Physical safety
 - Room arrangement (access to exit, not having back to a door, noise, lighting)
- Psychological Safety
 - Provider constancy & dependability
 - Patient choice and empowerment

Patient case question

Which of the following would you consider implementing when meeting with “Arnie” utilizing trauma informed care principles?

- A. Reduce excessive environmental noise
- B. Use open questions and shared-decision making to discuss treatment options
- C. Offer connection to peer support
- D. Clearly communicate policies/procedures and how best to reach you if there is a concern
- E. All the above

AFFIRM RESILIENCE

“Trauma-informed care recognizes symptoms as originating from adaptations to the traumatic event(s) or context. **Validating resilience is important even when past coping behaviors are now causing problems.** Understanding a symptom as an adaptation reduces a survivor’s guilt and shame, increases their self-esteem and provides a guideline for developing new skills and resources to allow new and better adaptation to the current situation.”

-Elliot et al., 2005, p. 467

TAKE HOME POINTS

- Trauma-informed care principles can help support engagement in PTSD + AUD
- Presence of AUD should not preclude treatment for PTSD
- Evidence-based guidelines are available to support psychotherapy and pharmacotherapy choices for both PTSD and AUD
- Topiramate, prazosin, and desipramine have evidence to support use in co-occurring PTSD+AUD

QUESTIONS?

Thank you for attending!