



# ISTSS 2019

## OUR NEWSLETTER

Thank you to everyone who submitted contributions and nominations for Volume 3, Issue 1 of our bi-annual newsletter! We are delighted to be able to feature several original articles contributed by our SIG members examining effective implementation of PTSD-SUD treatment, discussion of an F31 examination of PTSD-AUD, and a discussion of suicide risk and planning in the context of PTSD-SUD. We have also included a spotlight on our new co-chair, Dr. Nicole Weiss, and a summary of the featured trauma/SUD articles shared via the listserv over the past six months.

We hope you find the newsletters helpful and interesting! We welcome feedback on how we can improve the newsletters to make them more useful to our SIG membership.

Sincerely,

Anne N. Banducci and Nicole H. Weiss (SIG Chairs / Newsletter Editors)

Lia J. Smith (SIG Student Co-Chair / Newsletter Assistant Editor)

## SIG: MISSION STATEMENT

The ISTSS Trauma and Substance Use Disorders (SUD) SIG was founded in 2010. The SIG offers an international multidisciplinary forum for discussion, networking, and collaboration about clinical and research practices relevant to traumatic stress and SUD. The overarching aims of the SIG include:

1. advocating for greater recognition, scholarly attention, and clinical knowledge regarding the highly prevalent and difficult-to-treat occurrence of SUD among trauma-exposed populations with and without PTSD.
2. fostering basic, clinical, translational, and implementation research efforts relevant to traumatic stress and SUD via discussion and collaboration among multidisciplinary members from various regions of the world.
3. advancing evidence-based clinical practices relevant to the assessment and treatment of (1) SUD among trauma-exposed populations; (2) concurrent PTSD and SUD; and (3) PTSD among substance using populations.
4. supporting dissemination and implementation efforts for relevant evidence-based treatments.
5. advancing prevention of SUD in the aftermath of trauma exposure, and prevention of PTSD among individuals with a history of SUD.



## INSIDE THIS ISSUE

Article Submission .....	2
Notes from the Field .....	4
Spotlight SIG Member .....	5
Clinical Corner .....	6
Article Submissions .....	8
Nominations for Spotlights .....	8
Highlighted Research .....	8

## JOINING THE SIG

1. Log into the ISTSS website as a member
2. Under "For Members," click on "Special Interest Groups"
3. Under "Get Involved, join a Sig," click on the form link
4. Scroll through the Listservs/Communities tab
5. Choose #39—"Trauma and Substance Use Disorders"
6. Click "Save"



## SPOTLIGHT MEMBERS

### **Christal Badour, PhD**



Dr. Christal Badour is an assistant professor in the department of psychology at the University of Kentucky. She received her PhD in clinical psychology from the University of Arkansas and completed her predoctoral internship in the Traumatic Stress Track of the Charleston Consortium internship program at the Medical University of South Carolina and Ralph H. Johnson Veterans Affairs Medical Center. Dr. Badour also completed a National Institute of Mental Health (NIMH)-funded postdoctoral fellowship in Traumatic Stress Research at the National Crime Victims Research and Treatment Center at the Medical University of South Carolina.

Dr. Badour's research focuses on identifying and understanding affective mechanisms involved in the development, maintenance, and treatment of psychopathology following traumatic experiences. Much of this work involves examining the role of emotion expression and regulation in posttraumatic stress disorder (PTSD) with a particular emphasis on moral emotions such as disgust, shame, and guilt. Dr. Badour is also interested in identifying unique and shared processes underlying co-occurring symptoms of PTSD and substance use disorders. This work is primarily focused on identifying specific mediators and moderators of treatment change in order to enhance existing interventions and to guide development of new targeted interventions.

## ORIGINAL WORK BY OUR SIG MEMBERS

### **Integrated Treatment for Comorbid PTSD and Substance Use Disorders: Moving Beyond “Should We Do It?” To “How Can We Do It Most Effectively?”**

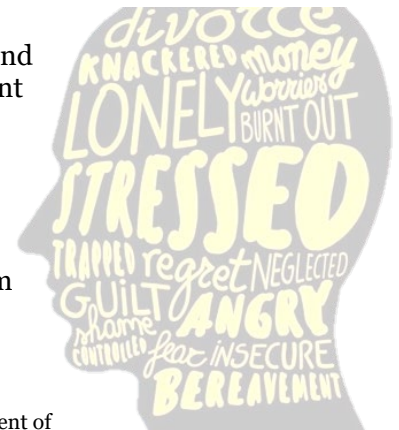
**By: Christal Badour, PhD**

The traditional view holds that comorbid posttraumatic stress disorder (PTSD) and substance use disorders (SUDs) should be treated sequentially. That is, patients with comorbid PTSD/SUD should first receive SUD treatment and demonstrate a sustained period of abstinence (e.g., 6-months) prior to initiating PTSD treatment. Reviews of several randomized controlled trials now challenge this notion, demonstrating that integrated treatments that address PTSD and SUD symptoms concurrently, including coping skills-based interventions (e.g., Seeking Safety) and trauma-focused (TF) cognitive-behavioral interventions (e.g., Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure [COPE]), do not result in increases in substance use frequency, rates of relapse, or severity of PTSD symptoms (Roberts et al., 2015; Simpson, Lehavot, & Petrakis, 2017). There is mounting evidence that integrated TF therapies, in particular, yield greater improvement in PTSD symptoms when compared to standalone SUD treatment or coping skills-based integrated interventions (Back et al., 2019; Norman et al., 2019; Ruglass et al., 2017; Simpson et al., 2017).

Though the findings for integrated TF therapy for PTSD/SUD are promising, we still have a long way to go. At best, integrated TF interventions tend to yield modest improvements in both PTSD and SUD symptoms, and are associated with high rates of dropout (Simpson et al., 2017). To address this limitation, many investigators are now moving beyond basic questions of safety and efficacy in favor of inquires such as 1) Which patients with PTSD/SUD are most likely to benefit from TF integrated treatment?; 2) How can treatment be modified to reduce drop out?; and 3) How can we most effectively deliver the essential components of treatment in order to maximize benefits? As a result of these types of refined questions, we now have emerging evidence that patients with more severe PTSD (Ruglass et al., 2017) or greater emotion dysregulation at the start of treatment (Hien, Lopez-Castro, Papini, Gorman, & Ruglass, 2017) are likely to derive more benefit from an integrated TF treatment compared to a standalone SUD treatment. We also have evidence that PTSD/SUD patients with a single SUD diagnosis (vs. poly-SUD; Jeffirs et al., 2019), and those who report greater reduction in distress and craving across sessions (Badour et al., 2017) are likely to see greater improvements in both PTSD and SUD symptoms when receiving an integrated TF treatment. In contrast, history of traumatic brain injury (Gros et al., 2017), PTSD diagnosis preceding onset of SUD (Bountress, Badour, Flanagan, Gilmore, & Back, 2018), and intimate partner relationship problems (Flanagan et al., 2017) have all been linked to less improvement in PTSD following integrated TF treatment.

Predictors of early dropout from integrated TF treatment include more severe baseline PTSD (Szafranski et al., 2017) and higher craving and distress following imaginal exposure (Jarnecke et al., 2019). However, recent evidence suggests that between 41-68% of patients experience clinically significant improvement in alcohol use, PTSD, and depression prior to drop out, suggesting that dropout alone may *not* be the best indicator of treatment non-response or non-acceptance (Szafranski et al., 2019). More work is needed to understand patterns of symptom improvement and drop out. Finally, there may be utility reducing the length of sessions (Mills et al., 2017) or tailoring the number of sessions (Badour & Rush, 2017) to better individual needs.

In short, we have made tremendous strides toward improving options for evidence-based integrated treatments for patients with co-occurring PTSD/SUD, and we are now beginning to examine important moderators and mediators of treatment outcome that are likely to directly inform improvements in both treatment efficacy and retention. However, significant barriers remain to implementation, as many clinicians continue to express concern regarding the safety of assessing for and treating PTSD among patients with SUDs (Norman & Hamblen, 2017). Focused attention to bridging the research-practice gap is sorely needed if we hope to get our ever-improving interventions to the patients who could potentially benefit from them.



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## NOTES FROM THE FIELD

### Examining PTSD and Alcohol Use with an F31 Predoctoral Training Grant

By: Matthew T. Luciano, MS

#### SPOTLIGHT MEMBERS

#### Matthew T. Luciano, MS



Matt Luciano is a 5<sup>th</sup> year student in the Clinical Psychology Doctoral Program at The University of Memphis. He graduated from Syracuse University and subsequently worked for two years at the Syracuse University Psychology Department. He spent an additional two years as a psychology technician at the National Center for PTSD in Boston, MA. His research interests are in the etiology and treatment of co-occurring PTSD and alcohol misuse. Matt is interested in testing novel theoretical approaches (e.g., behavioral economics) that may help to further understand this complex comorbidity (outside of the already widely studied "self-medication hypothesis"). Matt recently received a NRSA F31 grant that will fund his dissertation and serves as the Student Section Chair for ISTSS. In July of 2019, he will begin his pre-doctoral clinical internship at the San Diego VA Consortium.

Posttraumatic stress disorder (PTSD) and co-occurring alcohol use disorder represent a significant public health concern. However, traditional treatment approaches are often associated with high dropout and modest treatment gains. Thus, there is a pressing need to target underlying mechanisms of comorbidity to develop effective and brief interventions. To date, these dual conditions have primarily been explained through the self-medication hypothesis (whose core assumptions suggest that aversive internal states motivate substance use as a form of negative reinforcement). Although self-medication is a useful framework, and certainly contributes to alcohol use among those with mental health symptoms, critics have pointed to several problems with this conceptualization that warrant an examination into complimentary mechanisms of action.

One novel approach to understanding and treating these conditions is behavioral economics, a meta-theory that integrates microeconomic concepts and operant psychology in order to better understand human decision-making. Behavioral economists often consider alcohol misuse as a "reinforcer pathology" which relies on a strong desire to use alcohol (i.e., alcohol value), a deficit in available substance-free activities (i.e., limitations of choice), and an individual preference for immediate rather than delayed rewards (i.e., poor future orientation). Indeed, these constructs have been shown to account for significant variance in alcohol use across a number of samples, including young adults exposed to trauma.

In fact, behavioral economics may be especially relevant for individuals with PTSD. In order to make the choice to use a substance, the benefit/cost ratio of substance use must be greater than the benefit/cost ratios of other available activities. PTSD-related anhedonia may devalue the perceived benefit of engaging in constructive or relaxing activities (i.e., there will be an expected lack of enjoyment from these activities) while PTSD-related negative beliefs about the world may increase the perceived risk of engaging in these same activities (i.e., engaging with the world may be perceived to be more dangerous for those with PTSD). At the same time, PTSD-related avoidance may increase the perceived benefit of alcohol (due to its anxiolytic effects) while also leading to fewer available substance-free alternatives.

With a burgeoning literature supporting behavioral economics in trauma-exposed populations, we are beginning to explore the potential application of these mechanisms as targets for intervention. Of particular interest to behavioral economists are small interventions, or "nudges," that act on one's environment or perception of choice. In particular, a social norm nudge can help guide decision-making by comparing the behavior of an individual to his or her peers. This is not dissimilar to personalized drinking feedback (PDF) interventions, which incorporate normative and personalized feedback on alcohol misuse with the goal of decreasing alcohol risk behavior. Though these PDF interventions are often associated with small effect sizes, supplementing them with a behavioral economic informed feedback intervention may be beneficial for reducing consumption and alcohol-related problems.

In my NIAAA-funded F31 grant, I am administering a two-session PDF intervention to a sample of veterans with PTSD and patterns of hazardous drinking. The first session mirrors a traditional PDF intervention and includes personalized and normative feedback on alcohol use. The second session focuses on improving mental and behavioral health through behavioral economic mechanisms of action. In other words, we are supplementing our alcohol-focused nudge with personalized content aimed at (1) increasing substance-free reinforcement in an individual's environment, (2) decreasing impulsive avoidance activity, and (3) highlighting the value of healthy reinforcing activity. While we are still in the data collection phase, it appears that this intervention may have some level of acceptability and feasibility among a small sample of veterans. Moving forward, a randomized-controlled trial will be necessary to demonstrate treatment efficacy.

## SIG MEMBER SPOTLIGHT

**An introduction to the newest SIG co-chair, Dr. Nicole Weiss.**

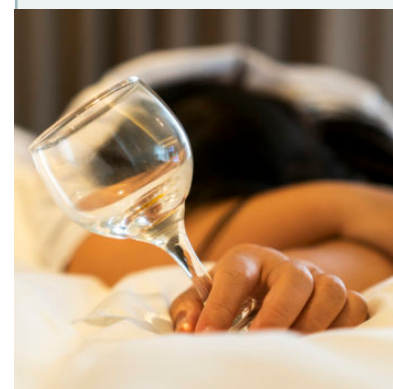
Dr. Nicole H. Weiss is an Assistant Professor of Psychology at the University of Rhode Island and Director of the Study of Trauma, Risk-taking, Emotions, and Stress Symptoms (STRESS) Lab. Dr. Weiss received her Ph.D. in Clinical Psychology from Jackson State University in 2013, following completion of her Predoctoral Internship at the Mississippi Consortium (G.V. [Sonny] Montgomery VAMC/University of Mississippi Medical Center). In 2013, Dr. Weiss was awarded a National Institute on Drug Abuse T32 Postdoctoral Fellowship in Substance Abuse Prevention Research in the Department of Psychiatry at the Yale University School of Medicine.

As an early stage investigator, Dr. Weiss has already made impressive contributions to the fields of traumatic stress and substance use, authoring over 70 peer-reviewed publications in these areas and being recognized by several early career awards, including a Rising Star Award from the Association for Psychological Science; Clinical Research Loan Repayment (L30) and Early Career Travel Awards from the National Institute on Drug Abuse (NIDA); and the 2019 University of Rhode Island Early Career Faculty Research and Scholarship Excellence Award in Social Sciences and Humanities. Her research examines affective mechanisms – most notably emotion dysregulation – underlying the co-occurrence of posttraumatic stress disorder (PTSD) and substance use.

Dr. Weiss' recent work has focused on the contribution of emotion dysregulation, stemming from positive emotions, to co-occurring PTSD and substance misuse. Her research in this area indicates that emotion dysregulation, due to positive emotions, is elevated among individuals with PTSD and is associated with greater alcohol and drug use. One explanation proposed by Dr. Weiss is that some positive emotions (e.g., excitement) elicit physiological arousal among individuals with PTSD that is experienced as aversive. In turn, substance use may function to reduce arousal stemming from these positive emotions, consistent with the notion that the motivational basis of substance use is the reduction or avoidance of aversive internal states. Dr. Weiss is currently the PI on a K23 grant from NIDA that further explores the roles of emotion dysregulation stemming from both negative and positive emotions in the co-occurrence of PTSD and substance use, using laboratory and experience sampling methods. The overarching goal of Dr. Weiss' research is to inform the development and refinement of treatments for co-occurring PTSD and substance use.

### SPOTLIGHT MEMBERS

**Nicole H. Weiss, PhD**





## SIG CLINICAL CORNER

**An original article written by Leslie Wright, Ph.D.**

*Dr. Wright is a staff psychologist, Suicide Prevention Coordinator/Team Lead, and Military Sexual Trauma Care Coordinator at the VA Boston Healthcare System.*

### **Current Considerations for Suicide Risk and Treatment Planning within the Context of PTSD-SUD**

Safety is always a top priority when working with populations diagnosed with posttraumatic stress disorder (PTSD) and substance use disorders (SUD). Not only are the rates of suicide attempts and deaths by suicide higher in individuals with PTSD, SUD, and co-occurring PTSD and SUD (Dore, Mills, Murray, Teesson, & Farrugia, 2012; Bryan, McNaughton-Cassill, Osman, & Hernandez, 2013; Nock, Hwang, Sampson, & Kessler, 2010; Suris, Link-Malcolm, & North, 2011), but also many behaviors that occur in the context of these diagnoses can be life-threatening, outside of the context of explicit suicidal intent. Furthermore, self-report is not always a reliable indicator of risk for suicide, so careful attention must be paid to self-report regarding suicidal ideation and intent, as well as to patterns of behavior that could have negative outcomes (Berman, 2018).

Many individuals with diagnoses of PTSD-SUD engage in behaviors that are risky and potentially life-threatening, even in the absence of suicidal thoughts and intent. This makes assessment of suicide risk and treatment planning more challenging. Attention must be paid to both thoughts and behavior, in particular behavior that has imminent potential for harm, intentional or not. Especially in an age where there are more potent opioids, and an increasing number of synthetic drugs of abuse, the risk for harm and mortality when using substances has increased dramatically. In particular, opioids are of immense concern, and individuals stuck in a cycle of substance use may have experienced many attempts at sobriety before finding a course of treatment that works for them. This may engender a sense of hopelessness and despair, both concerning risk factors for suicide. Similarly, individuals with PTSD may engage in patterns of harmful or self-destructive behavior, such as reckless driving, taking unnecessary risks, and having firearms at the ready for protection. Many firearm owners are knowledgeable and responsible about safety precautions, like locking firearms and storing ammunition separately. However, for someone who is intoxicated, or in acute distress related to PTSD symptoms (or both), it is not safe to handle firearms.

Friends and family members are often concerned about harm, whether or not their loved one has ever explicitly expressed an intent to die or made a suicide attempt, due to behavior that is concerning as a result of acute intoxication, withdrawal, and/or PTSD symptoms. Concerning symptoms may include hypervigilance, sense of foreshortened future, or negative alterations in cognition and mood (which can also be exacerbated by the physiological effects of intoxication or withdrawal). Impulsivity and high-risk behavior must be addressed clinically, as they can be impacted by the effects of acute intoxication, withdrawal, and/or PTSD symptoms.



Clinically, there are many interventions that may help to mitigate risk for death by suicide in this vulnerable population. In the suicide prevention literature, the most effective way to prevent an attempt or death by suicide is lethal means safety counseling (Barbar & Miller, 2014). In the SUD treatment field, it is essential to provide education about the risk for overdose, in particular to opioid-users, as well as to provide easy access to Narcan and

training in how to administer Narcan. Reducing access to lethal means (e.g., opioids) is often much more easily accomplished in an inpatient psychiatric unit or residential treatment facility; however, clients can be counseled on an outpatient basis, for example using harm-reduction strategies and opioid replacement therapies. When it comes to firearms and lethal means safety, people may be reluctant to disclose firearm ownership to healthcare providers, due to concerns that their firearms will be taken away. However, it is never the goal of healthcare providers to restrict someone's rights. Clinicians are advised to approach this conversation from a non-judgmental stance, and to encourage active participation in a discussion about how to improve safety, in particular during times of emotional distress related to PTSD (such as anniversaries, stressful times) and especially if one has recently had a suicidal



crisis. One helpful tip is to approach the discussion from a normalizing perspective. It is important to not stigmatize firearm ownership; those who view possession of firearms as a means to protect themselves and their families may be sensitive to the threat of having their firearms taken away. Many clinicians in the field refer to “reducing access to lethal means”, however, the nomenclature is shifting towards “lethal means safety” to promote the idea that the goal is not to add a restriction, but rather to promote safety during periods of crisis and/or acute distress. The objective is to engage clients in a patient-centered discussion about their health and measures they can implement to enhance their safety and well-being. Other useful interventions

include safety planning, providing information about emergency services and crisis hotlines, and collaboration with an interdisciplinary treatment team whenever possible.

**For more information, please see:**

National Suicide Prevention Lifeline: <https://suicidepreventionlifeline.org/>

Veterans Crisis Line: <https://www.veteranscrisisline.net>

American Foundation for Suicide Prevention: <https://afsp.org>

Rocky Mountain MIRECC for Suicide Prevention: <https://www.mirecc.va.gov/vision19/>

Lethal Means Counseling: <https://www.hsph.harvard.edu/means-matter/lethal-means-counseling/>

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## ARTICLE SUBMISSIONS

The Trauma and Substance Use Disorders SIG welcomes submissions to the bi-annual newsletter. The purpose of the newsletter is to communicate SIG-related news and disseminate information regarding research, clinical practice, and training in trauma and substance use. Article submissions can include commentaries on research, clinical practice, or training. Submissions from students are welcome! Sample topics include research participant recruitment and retention, optimal training in PTSD/SUD comorbidity, book reviews, clinical dialogues, student issues, and dissemination and implementation discourse.

Questions regarding article submissions should be addressed to the SIG Chairs. Articles should be submitted via e-mail to:

Dr. Anne Banducci  
([Anne.Banducci@va.gov](mailto:Anne.Banducci@va.gov))  
&  
Dr. Nicole Weiss  
([nicole\\_weiss@uri.edu](mailto:nicole_weiss@uri.edu))

**Articles should be no longer than approximately 3 double-spaced pages.**

**Brief articles are preferred!**

## NOMINATIONS FOR SPOTLIGHTS

The Trauma and Substance Use Disorders SIG welcomes nominations for students, researchers, and clinicians to be "spotlighted" in an upcoming newsletter. Self-nominations are accepted! Nominations should include a brief, one paragraph nominating statement and CV of the nominee.

Nomination materials should be addressed to the SIG Chairs via email:

Dr. Anne Banducci  
([Anne.Banducci@va.gov](mailto:Anne.Banducci@va.gov))  
&  
Dr. Nicole Weiss  
([nicole\\_weiss@uri.edu](mailto:nicole_weiss@uri.edu))

## HIGHLIGHTED RESEARCH

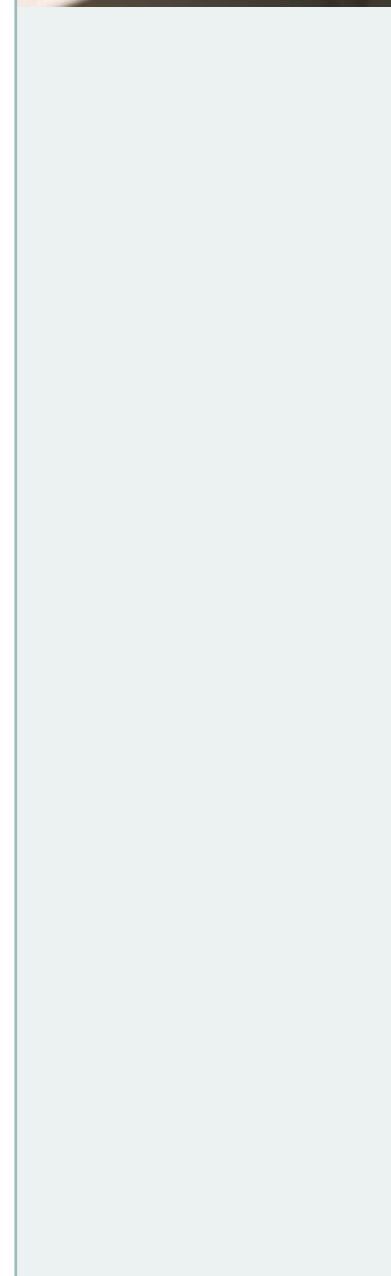
**The below-listed articles were disseminated to members via the ISTSS SIG listserv - monthly research updates since our last newsletter.**

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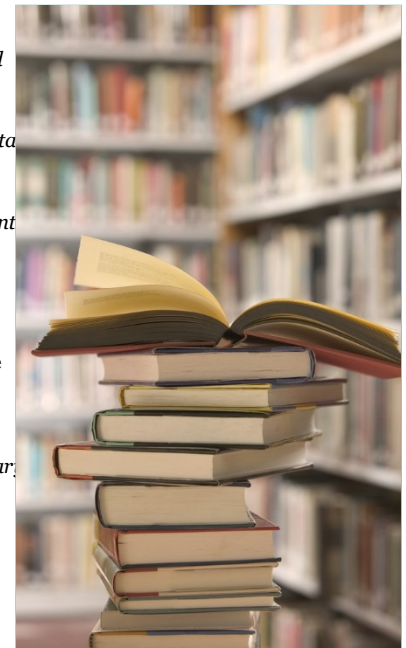


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