Focused Clinical Multi-Disciplinary ISP Final Project: Substance Use Disorder and PTSD

Rationale:

Multiple theories about the association between Post Traumatic Stress Disorder (PTSD) and Substance Use Disorder (SUD) have been proposed, but there is yet to be a common consensus on their exact relationship. Regardless of the etiology of their association, it is reasonable to suggest that the interaction between SUD and comorbid PTSD is complex. The intention of this project was not to dive deeper into the suggested theoretical models, but rather to focus on understanding how these conditions affect patients and on a pragmatic approach to treatment. This was based largely in principle on two observations from prior studies. One of which was the fact that patients with the dual SUD/PTSD are more likely to struggle with treatment for substance use disorder in regards to retention and periods of abstinence. Second was the realization that patients with comorbid disease have higher rates of homelessness, physical health problems, psychiatric comorbidities, and psychosocial impairment when compared to individuals with a single disorder. As such, the goal of this project was to gain a better understanding of the challenges associated with treating these patients and to also develop a greater understanding of the "best" practice approach to treatment.

Project Objectives:

My overall goal for this project was to become an expert in caring for a patient with substance use disorder and co-occurring PTSD. Here are the specific objectives outlined in the ISP proposal:

1. Learn about the pharmacologic and non-pharmacologic management and treatment of patients with SUD and PTSD.
2. Become well acquainted with screening patients for SUD and PTSD.
3. Work closely with the multi-disciplinary SARRTP treatment team to learn about their different roles in treating patients and preventing relapse.
4. Gain a greater first-hand understanding of addiction, the recovery process, and preventing relapse.
5. More specifically, I would like to learn how to lead addiction based group therapy sessions, and PTSD based group therapy sessions.
6. Get involved with the social work and addiction therapist aspects of SUD and follow patients post program discharge during their recovery home stay.
7. Function at the level of a sub-intern on SARRTP and manage a panel of my own patients with SUD and PTSD.
8. Understand what it means to struggle with addiction and gain a greater appreciation of the chronic nature of the disease. Learn about the life-long cycle of sobriety and relapse.

Methods:

For eight weeks I worked on the SARRTP unit and functioned at the level of a sub-intern for Dr. Groban. During that time I was responsible for the medical management of anywhere from two to six patients. In addition to my role as a sub-intern, I also collaborated with Dr. Haller to assist in managing the psychological care of my patients with PTSD. This included weekly meetings with Dr. Haller to discuss my project and patient care, co-facilitating group based Cognitive Processing Therapy sessions, observing individual Prolonged Exposure therapy sessions, and attending outpatient based group therapy PTSD sessions. In addition to working with Dr. Groban and Dr. Haller, I also spent time each week observing Dr. Schuckit interviewing, and assessing, new patients and then discussing a variety of psychiatric topics to include SUD and PTSD. Lastly, during my eight weeks working on the SARRTP unit I spent time on a daily basis working with the staff social workers and addiction therapists to manage patient care plans, complex social issues, discharge planning, and observing/participating in process group.

Achievements/Personal impressions from my time on SARRTP:

1. Substance Use Disorder and PTSD are chronic disease states. The idea that individuals will seek treatment, get help, and then be cured is unrealistic. Both conditions are more cyclic in nature and it would likely be a better to approach to look at each condition and consider "how well controlled" it is at any given time. This would mirror that of other chronic disease states such as hypertension and diabetes. Disease labels matter both psychologically for the patient and for the provider. Getting patient's to understand that what they are experiencing is chronic, and essentially un-curable, may help with avoiding triggers, encourage regular attendance in support groups, and seeking help when things start to spiral downward.

2. Management with medications is adjunct. The root of treating patients with Substance Use Disorder and PTSD lies in psychological therapy. Medications can help reduce cravings and possibly restore some normality in neurochemical processing, but to achieve true sustained results requires counseling and/or group sessions. PTSD is a disease of avoidance, negative emotions, and self-deprecating cognitions and cannot be cured with medications alone. Treatment must include the processing of emotions, and I am convinced that this cannot occur with medication alone.

3. Psychological therapy is time and resource intensive. This creates significant barriers to care. There are limits to how many individual patients a therapist can see in one day when treatment sessions last 90 minutes. Group formats can help alleviate some of the strain, but they also come at the expense of compromising individual therapy with generalized group themes.

4. Substance Use Disorder with comorbid PTSD is catastrophic. Patients really struggle to function within society and have difficulty maintaining jobs and relationships. This often leads them to becoming homeless and having little to no access to healthcare.

5. Psychological therapy is difficult. Cognitive Processing Therapy and Prolonged Exposure Therapy require thinking and re-imagining traumatic events that have deeply scarred patients. Attending individual sessions during inpatient programs often leaves patients in tears and emotionally devastated. Convincing patient's to continue with therapy can be challenging, as PTSD symptoms typically get worse before they get better. Therapy becomes even more difficult in an outpatient setting as patients often times leave therapy sessions while emotionally activated and are faced with option of using drugs (as they have so often in the past) as a means of avoidance. It is easy to see how PTSD and Substance Use Disorder are almost synergistic and can create difficult patterns to break.

Personal Project Assessment:

Overall I would say that I accomplished the majority of the goals of my project. My main objective was to gain a better understanding of treating patients with PTSD and Substance Use Disorder. Specifically, I wanted to learn and understand the theory associated with Cognitive Processing Therapy and Prolonged Exposure. I feel that I accomplished this by successfully co-leading CPT groups and witnessing almost a full course of one-on-one PE sessions. It would be unrealistic to think that I could walk away from this experience and be able to successfully conduct CPT or PE on my own, but I certainly have a good understanding of what each entails and the theoretical approach behind them. I am confident in saying that at the completion of my project there were probably very few medical students that knew as much about the psychological approach to treating Substance Use Disorder and PTSD as I did.

One of my other goals was to function at the level of a sub-intern and I think that I also successfully completed this. I believe that it was helpful to the unit to have me present for two and months and provide some continuity between junior residents and medical students. At the completion of my project, I feel very confident in managing all aspects of medical care from the prospective of a junior psychiatry resident.

I also started out with the aim of working with other support staff such as addiction therapists and social workers to understand their role in therapy. I believe that this is another area in which I accomplished my goals. I gained a great deal of insight by managing discharges, identifying community resources, updating treatment plans, and participating in process group.

My project was not completely successful. There are two areas in particular where I failed to live up to my initial expectations when starting my project. These include

post-discharge patient follow up and a comprehensive literature study on Substance Use Disorder and PTSD.

Prior to starting my project it was pointed out by the ISP committee that I might struggle to follow up on patients after moving on to other rotations. This is certainly true, however, I found that the biggest obstacle to post discharge follow up was the fact that many patients lacked cell phones or went to VVSD where contact was limited. Attempts to follow up with patients at other scheduled appointments at the VA proved to be hit or miss as well. There was also some concern as to my ability to manage solo follow up with patients that might be relapsing without preceptor oversight. Ultimately, I would say that I was unsuccessful in the follow up of patients post-discharge. There were certainly systematic issues as well as challenges with the patient population, but I think that I could have found ways to overcome these barriers.

Lastly, the other objective that I was unable to complete was a comprehensive literature review. When I was initially outlining the goals of my project, I underestimated the amount of time that it would take to function as a sub-intern and a quasi-psychology intern (with no background or training in psychology I might add). In addition to fulfilling all the duties of a sub-intern and managing up to six patients, I had to devote a significant portion of time to reading CPT and PE manuals in order to learn the process and to understand the theory behind each. Additionally, I found it challenging at times bouncing between psychiatry meetings/obligations and psychology groups/individual sessions. Ultimately I prioritized my number one goal of really learning and understanding the psychological model of therapy over a comprehensive literature review.

References:

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