

ADVANCED CLINICAL SEMINAR: CO-OCCURRING DISORDERS

Cardwell C. Nuckols, PhD

cnuckols@elitecorp1.com

www.cnuckols.com

Attention Deficit/Hyperactivity Disorder

- Presentations

- Combined Presentation: Inattention and Hyperactivity-Impulsivity criteria met
- Predominantly Inattentive: Inattention criteria met and Hyperactivity-Impulsivity criteria not met but 3 or more symptoms present for the last 6 months
- Inattentive Presentation (Restrictive): Inattentive criteria met but no more than 2 symptoms from Hyperactivity-Impulsivity criteria present for the past 6 months
- Predominantly Hyperactive/Impulsive: Hyperactivity-Impulsivity criteria met but Inattentive is not met

Attention-Deficit/Hyperactivity Disorder

- **Substance-Related Disorders are familial**
- **3-5% in school-age kids**
- **Another 15-20% of school-aged population show transient behaviors suggestive of ADHD**
- **Boys are 3 times more likely than girls to have ADHD**
- **Symptoms decrease with age but 50-65% of children still manifest symptoms into adulthood (Korn & Weiss, 2003)**

Attention-Deficit/Hyperactivity Disorder

- **CO-OCCURRING-CHILDREN & ADOLESCENTS**
 - **54-84%-Oppositional Defiant Disorder**
 - **Substance Abuse problems**
 - **Conduct Disorder**
 - **Anxiety Disorders**
 - **Affective Disorders**

Harvard Mental Health Letter, “Treating ADHD in Children and Adolescents”, Vol 25, No. 4, October, 2008.

Attention-Deficit/Hyperactivity Disorder

- **CHARACTERISTICS**

- ***INATTENTION-DISTRACTIBILITY***

- ***IMPULSIVITY***

- ***HYPERACTIVITY***

Attention-Deficit/Hyperactivity Disorder

- **CHANGING PRESENTATION**

- **3-6 YEAR OLDS**

- **Motor restlessness**
 - **Insatiable curiosity**
 - **“Dangerously daring”**
 - **Vigorous, aggressive (breaks toys, accidents)**
 - **Demanding, argumentative**
 - **Noisy, interrupts**
 - **Low levels of compliance**

Attention-Deficit/Hyperactivity Disorder

- **CHANGING PRESENTATION**

- **6-12 YEAR OLDS**

- **Easily distracted**
 - **Homework poorly organized, incomplete with careless errors**
 - **Performs below expectations**
 - **Blurts out answers before question is completed**
 - **Interrupts others**
 - **Difficulties in peer relationships**
 - **Fails to wait turn**
 - **“Immaturity”**

Attention-Deficit/Hyperactivity Disorder

- **CHANGING PRESENTATION**
 - **12-18 YEAR OLDS**
 - Sense of inner restlessness
 - Poor follow-through
 - Fails to work independently
 - “Risky” behaviors-sex, drugs, driving
 - Poor self-esteem
 - Poor peer relationships
 - Difficulty with authority figures

Attention-Deficit/Hyperactivity Disorder

- **Preschool**
 - **Comprehensive Assessment**
 - **Followed by at least 8 weeks of behavioral intervention**
 - **Before consider the initiation of pharmacotherapy**
 - **Short –acting methylphenidate**

Attention-Deficit/Hyperactivity Disorder

- **STIMULANTS-FDA APPROVED**

- **Immediate Release**

- **Methylphenidate (Ritalin and Methylin)**
 - **D-Methylphenidate (Focalin)**
 - **Mixed Amphetamine Salts (Adderall)**
 - **D-Amphetamine (Dexedrine)**

- **Single pulse sustained release (swallow whole)**

- **Methylphenidate (Ritalin SR, Metadate ER, Methylin ER)**

Attention-Deficit/Hyperactivity Disorder

✘ STIMULANTS-FDA APPROVED

- ✘ Beaded delivery system (30% immediate and 70% 3hrs later)- (Metadate CD)
 - ✘ Can sprinkle beads into soft food
- ✘ Beaded delivery system (50% immediate release and 50% released 4 hrs later)- (Ritalin LA, Focalin XR, Adderall XR, Dexedrine Spansule)
- ✘ Osmotic-release system (OROS)- (18% immediate and 82% gradually released, replicates tid dosing)
 - ✘ Methylphenidate- Concerta
- ✘ Patches
 - ✘ Methylphenidate (Daytrana)-worn up to 9 hours per day (skin rash)
 - ✘ Lisdexamfetamine (Vyvanse-Adderall patch)

Attention-Deficit/Hyperactivity Disorder

- **NON-STIMULANT-FDA APPROVED**
 - **Immediate-release**
 - **Atomoxetine (Strattera)**
 - Potential severe liver damage (www.fda.gov)
 - Possible suicidal thoughts
 - **Extended-release**
 - **Guanfacine ER (Intuniv)**
 - Binds selectively to alpha 2A-adrenoreceptors in prefrontal cortex
 - » Linked to attention and executive function

Attention-Deficit/Hyperactivity Disorder

- **NON-STIMULANT-NOT FDA APPROVED**
 - **Immediate Release**
 - **Guanfacine IR (Tenex)**
 - **Clonidine (Catapres)**
 - **Bupropriion (Wellbutrin/Zyban)**
 - **Imipramine (Tofranil)**
 - **Nortryptiline (Aventil/ Pamelor)**
 - **Modafinil (Provigil)**
 - **Not FDA approved FOR CHILDREN OR ADOLESCENTS-**
Stevens-Johnson Syndrome concerns

Attention-Deficit/Hyperactivity Disorder

- **NON-STIMULANT-NOT FDA APPROVED**
 - Sustained Release
 - Bupropriion (Wellbutrin SR)
 - Bupropriion (Wellbutrin XL)
- **OTHER**
 - Omega-3 and Omega-6 fatty acids
(http://www.medscape.com/viewarticle/514770_print)

Attention-Deficit/Hyperactivity Disorder

- **STIMULANTS AS FIRST-LINE THERAPY ESPECIALLY WHEN NO CO-OCCURRING DISORDER EXISTS**
- **ATOMOXETINE MAY BE BETTER IF ANXIETY OR SUBSTANCE ABUSE EXIST OR IF FAMILY CONCERNED ABOUT ADDICTION**
- **MULTIMODAL TREATMENT STUDY OF CHILDREN WITH ADHD (MTA) SHOWED THE RELATIVE ADVANTAGE OF DRUG THERAPY BEGAN TO FADE AT 24 MONTHS AND SOMETIMES DISAPPEARED AT 36 MONTHS**
- **CLASSROOM INTERVENTIONS AND PARENT TRAINING TECHNIQUES HELPFUL WITH CHILDREN BUT LITTLE DATA EXISTS REGARDING EFFECTS ON ADOLESCENTS**

Attention-Deficit/Hyperactivity Disorder

- **Stimulants-Side Effects (greater with AMPH vs. MPH)**
 - Delayed sleep onset
 - Reduced appetite (most common sustained)
 - CAN ALSO SEE WITH STRATTERA
 - Abdominal pain
 - CAN ALSO SEE WITH STRATTERA
 - Jitteriness
 - Headache
 - Motor and vocal tics (controversial)
 - Growth effects
 - No adult variation in height or weight (NIH)
 - May be dose-related

Attention-Deficit/Hyperactivity Disorder

- **FINE TUNING**
 - **MORNING PERSON-RUNS OUT OF MENTAL ENERGY IN AFTERNOON**
 - **Avoid difficult afternoon classes**
 - **Encourage afternoon physical activity**
 - **Homework may require supplemental medication after school**
 - **Rebound symptoms more likely without supplemental**
 - **Concerta , Daytrana, Adderall XR**

Attention-Deficit/Hyperactivity Disorder

- **FINE TUNING**

- **AFTERNOON PERSON-HARD TO GET STARTED IN MORNING**

- **Schedule difficult classes in mid-day**
- **Wake-up early to give medication (short acting) and sustained release later**
- **Encourage morning physical activity**
- **Evaluate sleep patterns**
- **Ritalin LA, Focalin XR, Adderall XR, Daytrana**

ADHD: Management

- **Instruction to patient**
- **Behavioral**
 - **Assess abilities-**
 - **Structured environment**
 - **Training parents**
 - **Parent-Child Interaction Therapy (PCIT)**
 - Originally used with Child-Onset Conduct Disorder
 - May be effective with severe behavioral problems
 - Zisser, A., & Eyberg, S.M. (2010). Treating oppositional behavior in children using parent-child interaction therapy. In A.E. Kazdin & J.R. Weisz (Eds.) *Evidence-based psychotherapies for children and adolescents (2nd ed., pp. 179-193)*. New York:

ADHD: Management

- **CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder) is the nation's leading non-profit organization serving individuals with AD/HD and their families. CHADD has over 16,000 members in 200 local chapters throughout the U.S. Chapters offer support for individuals, parents, teachers, professionals, and others.**
 - **Attention Magazine**
 - **Free Discount Prescription Card offered by CHADD**
- **Communication with teacher**
 - **Daily Behavioral Report Cards (school-home notes)**
 - **School report invokes home-based contingencies**

BEHAVIORAL CONTINGENCIES

- **To Reduce Unwanted Behavior**
 - Present something undesirable (additional chores)
 - “Positive Punishment”
 - Keep something desirable (restrict access to video games)
 - “Negative Punishment”
- **To Increase Desired Behavior**
 - Provide something desirable (borrow the car)
 - “Positive Reinforcement”
 - Remove or reduce aversive conditions
 - “Negative Reinforcement”

Other Approaches

- I've seen some patients benefit from [LENS](#), a form of neurofeedback. I've seen other patients benefit from iLs, Integrated Listening Systems, a music-based [therapeutic listening](#) program. I'm a big fan of the [Cogmed program](#) for improving working memory, because it has more research behind it than other alternative therapies. My favorite "alternative treatments" are free: sleep, exercise, nutrition, meditation, stretching your brain with stimulating exercises, and [positive human contact](#) — known as love.

Other Approaches

- **Mindfulness Training**
 - UCLA study-reduction in impulsivity
- **Social Skills Training**
 - Failed to show effectiveness
 - May be failure to generalize skills
- **Homework Management Plan**
 - Secondary school youth
 - Specific amount of time each evening for homework even if youth states “no homework”
 - Pilot data indicates improvement
- **In-sight Driven Individual**
 - Generally less effective

Structure

- **AM Protocol**
 - White board or check-off sheet
- **Daily schedule**
 - Consistent wake-up time
 - Consistent home work time
 - Consistent “high energy” time
 - Consistent bed time
- **“SAFE” places**

Client and Family Resources

- www.adhdsupport.com
- www.myadhd.com

CONDUCT DISORDER

- **Disruptive, Impulse Control and Conduct Disorders includes Pyromania and Kleptomania**
- **Diagnostic Criteria the same**
 - **Three of the fifteen criteria**
 - **Aggression to people and animals**
 - **Destruction of property**
 - **Deceitfulness or theft**
 - **Serious violations of rules**

CONDUCT DISORDER

- **Subtypes similar**
 - **Childhood-Onset Type**
 - **Adolescent –Onset Type**
 - **Add: Unspecified Type-age of onset is unknown**
- **Callous and Unemotional Specifier**
 - **Must display at least two of the following characteristics persistently over at least 12months**
 - **Lack of remorse or guilt**
 - **Lack of empathy**
 - **Unconcerned about performance**
 - **Shallow or deficient affect**

CONDUCT DISORDER

- **CLINICAL COURSE**

- **As early as age 2-irritable temperament, poor compliance, inattentiveness and impulsivity**

- **Can lead to an initial diagnosis of ADHD or ODD and later to CD**
 - **Can occur despite good efforts by parents but commonly exist in unstable families**
 - **Sometimes a history of parental psychopathology including conduct and legal problems**
 - **Child's temperament difficulties lead to a "negative cycle" leading to parents giving up or resorting to more severe forms of punishment**

CONDUCT DISORDER

- **CLINICAL COURSE (CONTINUED)**
 - **ELEMENTARY SCHOOL**
 - **Continued aggressive tendencies toward adults and peers**
 - **Lack of social skills precludes appropriate interaction with peers and don't pay attention to social cues**
 - **Learn to use intense anger and aggression and lack ability to solve social problems**
 - **Comorbidity with ADHD is about 50% and may impede learning**

CONDUCT DISORDER

- **CLINICAL COURSE (CONTINUED)**

- **MIDDLE AND HIGH SCHOOL**

- By middle school age the three classes of behavior identified by Patterson and Forgatch are imbedded
 - *Noncompliance with commands*
 - *Emotional overreaction*
 - *Failure to take responsibility*
 - *Continued aggression creates peer rejection at the time it is most important leading to joining deviant peer groups*
 - Depression and anxiety are common (32-37%) as are learning disorders

CONDUCT DISORDER

- **CLINICAL COURSE (CONTINUED)**
 - Adolescent onset-when appropriate social skills with peers are developed and academic skills acquired, most reduce rate of conduct problems especially those without a history of aggression and whose conduct problems are mostly toward property (stealing)
 - Child onset- highly correlated with adult diagnosis of Antisocial Personality Disorder
 - Substance abuse is prevalent

CONDUCT DISORDER: Management

- **Child-Onset**
 - Non-normative peer relations
 - Onset prior to 10 yo
 - Aggressive style may be predatory
 - Genetics involved
 - Predominantly male
- **Management**
 - Goal
 - Business-like and behavioral
 - Observers

CONDUCT DISORDER: Management

- **Adolescent-Onset**
 - Normative peer relations
 - Onset after 10 yo
 - Emotional or passive-aggressive acting-out
 - Environmentally predominant
 - 50% male and female
- **Management**
 - Developmental
 - Personality immaturity
 - Role models and surrogates

CONDUCT DISORDER: MANAGMENT

- **No medications have been consistently effective when ADHD is not present. Stimulant medications can help control impulsivity, hyperactivity and inattention but doesn't help improve parent-child , teacher-child or peer relationships. Care should be taken if substance abuse in student or in family is reported.**
 - **Lithium and methylphenidate reduced aggressiveness in one set of studies**
 - **Carbamazepine (Tegretol) has been shown to be effective with aggressive behaviors**
 - **Clonidine may be helpful**
 - **1st line-methylphenidate, 2nd line-anticonvulsants, 3rd line-lithium**

CONDUCT DISORDER: MANAGEMENT

- **A multidisciplinary approach is required**
 - **For ODD and CD consider parent management training (PMT)**
 - **Parents are trained to alter the child's behavior at home**
 - **Based on theory that conduct problems inadvertently are developed and sustained by maladaptive parent-child interactions**
 - **PMT alters the pattern of ineffective parenting by encouraging the parent to practice prosocial skills (positive, specific feedback for desired behaviors, playing with the child), employ the use of natural and logical consequences, and use effective, brief and nonaversive punishments when encouragement and consequences are not effective**
 - **Severity of problem is key predictor of failure although the earlier the onset of treatment the better**
 - **“wrap arounds”**

CONDUCT DISORDER: MANAGEMENT

- **A multidisciplinary approach is required**
 - **Severe conduct problems in adolescent are the most treatment resistant**
 - **Treatment needs to be highly structured using behavioral techniques to improve communication and reinforce prosocial behaviors with clear discipline**
 - **Group treatment has benefits and drawbacks**
 - **Benefits for 12 and under**
 - **Best results with younger children when parents attend PMT while child attends social skills classes**

CONDUCT DISORDER: MANAGEMENT

- **A multidisciplinary approach is required**
 - *Boot camps yield good initial results but poorer long-term outcomes with higher rates of arrests and serious crimes found in graduates*
 - *Individual psychotherapy not proven effective but can facilitate compliance*
 - *Multisystemic package includes PMT, social skills training, academic support, pharmacological treatment of ADHD and depression and individual counseling as needed*

TRAUMA-AND STRESSOR-RELATED DISORDERS

- **Disorders in which exposure to traumatic or stressful events is listed explicitly as a diagnostic criterion**
 - ***REACTIVE ATTACHMENT DISORDER***
 - ***DISINHIBITED SOCIAL ENGAGEMENT DISORDER***
 - ***POSTTRAUMATIC STRESS DISORDER (PTSD)***
 - ***ACUTE STRESS DISORDER***
 - ***ADJUSTMENT DISORDERS***

TRAUMA-AND STRESSOR-RELATED DISORDERS

- **Social neglect-inadequate caregiving-** is a diagnostic requirement of both *Reactive Attachment Disorder* and *Disinhibited Social Engagement Disorder*
 - *Reactive Attachment Disorder expressed as an internalizing disorder with depressive symptoms (inhibited, emotionally withdrawn, minimal responsiveness to others)*
 - *Disinhibited Social Engagement Disorder expressed as disinhibited and externalizing behaviors (approaches and interacts with*

TRAUMA-AND STRESSOR-RELATED DISORDERS

- **These disorders share a close relationship with Anxiety Disorders, Obsessive-Compulsive and Related Disorders and Dissociative Disorders**
- **Psychological distress following trauma yields a heterogeneous response (often mixed)**
 - *In some cases the response can be understood in an anxiety or fear-based context*
 - *In others the clinical presentation is one of anhedonia and dysphoria, externalizing anger and aggression or dissociation*

TRAUMA-AND STRESSOR-RELATED DISORDERS

- ***Posttraumatic Stress Disorder***
 - Three major symptom clusters in DSM-IV now four symptom clusters
 - ***Intrusion symptoms***
 - Includes dissociative reactions (flashbacks) where individual feels or acts as if the traumatic event were reoccurring
 - ***Persistent avoidance of stimuli***
 - Includes avoidance of memories, thoughts, people and places that remind the individual of the trauma

TRAUMA-AND STRESSOR-RELATED DISORDERS

- Three major symptom clusters in DSM-IV now four symptom clusters (continued)
 - *Negative alterations in cognition and mood associated with the traumatic event*
 - Includes inability to remember aspects of the trauma, altered world view and anhedonia
 - *Marked alterations in arousal and reactivity (includes irritable behavior or angry outbursts and reckless or self-destructive behavior)*
 - Includes irritable and angry outbursts, hypervigilance and exaggerated startle response

VARIABLES

- **51 adults sexually and emotionally abused during childhood were imaged with MRI technology**
- ***Various forms of childhood abuse correlated between specific forms of maltreatment and thinning of the cortex in precisely the regions of the brain involved in perception and processing of the type of abuse***

VARIABLES

- *Somatosensory cortex in the area of the female genitals are thinner in women survivors of sexual abuse in childhood*
- **Emotional mistreatment associated with reduction in thickness of cerebral cortex in specific areas associated with *self-awareness, self-evaluation and emotional regulation***
- *Association between experience-dependent neural plasticity and later health problems*

VARIABLES

- Speculated regional thinning of cortex may serve as a protective mechanism immediately shielding the child from the experience of abuse by blocking the sensory experience
- This may lead to behavioral problems in later life
 - *Cortical representation fields can be smaller when certain sensory experiences are damaging or developmentally inappropriate*

Heim, Mayberg, Mletzko, Nemeroff and Pressner. “Decreased Cortical Representation in Genital Somatosensory Field After Childhood Sexual Abuse”. *Am J Psychiatry*, June 1, 2013.

COMPLEX POSTTRAUMATIC STRESS DISORDER

- ***PHYSIOLOGICAL***
 - AFFECT REGULATION AND IMPULSE CONTROL
 - SOMATIZATION AND MEDICAL PROBLEMS
- ***SELF AND IDENTITY***
 - ALTERED SELF AND OTHER PERCEPTION
 - ALTERED WORLD VIEW
- ***CONSCIOUSNESS***
 - ALTERED ATTENTION AND CONSCIOUSNESS

Physiological

- **Acute Effects of Hyper-arousal**
- **Chronic Effects of Hyper-arousal**
- **Acute Effects of Dissociation**
- **Chronic Effects of Dissociation**

Acute Effects of Hyper-Arousal

- **Increased Sympathetic NS (Fight/Flight)**
- **Decreased pain in the short run**
- **Decreased immune response**
 - **Cortisol reduces inflammation**
 - **Cortisol suppresses immune response**

Chronic Effects of Hyper-Arousal

- **Cortisol reserves get used up (hypocortisolemia)**
- **Immune system becomes overactive**
 - **Rebound effect: get sicker than if not stressed**
 - **Increased inflammatory response**
 - **Increased risk of autoimmune disorders**
- **Osteoarthritis**
- **Crone's Disease**
- **Multiple Sclerosis**

Acute Effects of Dissociation

- **Increased Parasympathetic NS**
 - **Decrease:**
 - Heart rate
 - Respiration/O₂ requirements
 - Blood pressure
- **Other Effects:**
 - **Increased Endorphins/Enkephalins**
 - **Decreased intensity of inflammatory response**
 - **Decreased sensation of pain**

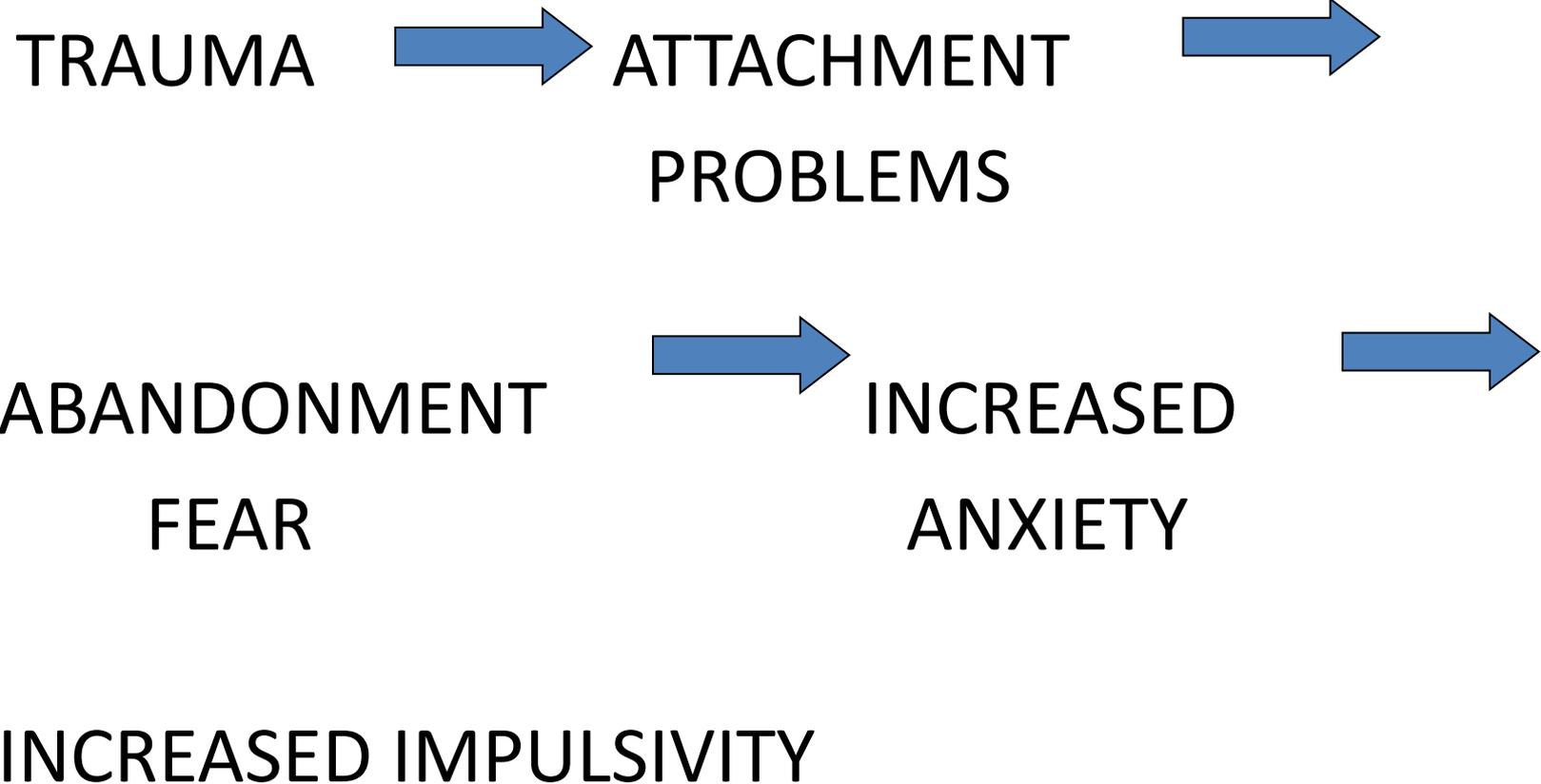
Chronic Effects of Dissociation

- **Depleted supply of endorphins leads to:**
 - **Chronic pain**
 - **Substance abuse (attempt to recharge endorphins)**
 - **Social isolation**
 - **Memory impairment**
 - **Depression**

Self And Identity

- **Insecure attachment**
 - **Disorganized type**
- **Disorganized attachment themes**
 - **HELPLESSNESS**
 - **Abandonment**
 - **Betrayal**
 - **Failure**
 - **Dejection**

Abandonment Fear



Self And Identity

- **Disorganized attachment themes**
 - **COHERSIVE CONTROL**
 - Blame
 - Rejection
 - Intrusion
 - Hostility
- **Borderline Personality Disorder**

Consciousness

- **Dissociative adaptations**
 - **Automatization of behavior**
 - **Deficits in judgment, planning and goal-directed behavior**
 - **Compartmentalization of painful memories and feelings**
 - **Detachment from awareness of emotions and self**
- **Naltrexone**

Consciousness

- **Dissociative detachment may numb the body as well**
- **Smaller hippocampal volume**
 - **Rich in glucocorticoid receptors**
 - **Smaller the size the greater the level of dissociation**
- **Higher connectivity between the right insula and the left ventrolateral thalamus-involved in emotion and consciousness**

STAGES OF TREATMENT

- **STAGE ONE- STABILIZATION, TRUST AND SAFETY**
 - Alliance building, safety, affect regulation, support, self-care and stabilization issues
- **STAGE TWO-TRAUMA WORK**
 - Resolution and integration of trauma
- **STAGE THREE- LEARNING TO LIVE GACEFULLY IN THE MOMENT**
 - Self and relational development and daily life enhancement

STAGE ONE- STABILIZATION, TRUST AND SAFETY

- **TREATMENT OF LONGER DURATION**
- **SETTING LIMITS**
- **ATTACHMENT ISSUES**
- **PSYCHOEDUCATION**
 - **EXPLAIN TREATMENT**
 - **EXPLAIN COMPLEX PTSD**

STAGE ONE- STABILIZATION, TRUST AND SAFETY

- **What has changed?**
- **Closed contract**
- **Stabilization**
 - **Physiological**
 - **Psychological**
 - **Social**
 - **Spiritual**
- **Trust**
 - **Validate feelings**
 - **Map of the World**
 - **Rapport**

PSYCHOLOGICAL STABILIZATION

- **Affect Regulation**

- **Moving attention away from internal “cycling”**

- **Panic**
 - **Flashback storms**
 - **Intrusive thoughts**
 - **Brief psychotic breaks**

- **Attention toward**

- **Non-autonomic body sensations**
 - **Details of room**
 - **Therapists voice**

PSYCHOLOGICAL STABILIZATION

- **Affect Regulation**
 - Breathing
 - Identifying and discriminating emotions
- **Cognitive interventions**
 - Normalization of experience
 - Reframing
 - Assessing beliefs and assumptions about trauma
- **Behavioral interventions**
 - What are triggers?
 - What do I think and do after the trigger?

Behavioral Safety Plan On 3x5 Index Card

MY PERSONAL SAFETY PLAN

- Remember that symptoms go away
- Write down the symptoms on a piece of paper
- I can write in my journal
- I can call my sponsor (299-289-5555)
- I can call my lover (299-426-1776)
- I can read from my favorite recovery book
- I can read affirmations

TRUST

- **Past history of assessment**
- **Past experience with rules**
- **Power issues in therapeutic relationship**
- **Case**
 - **35 y.o. female (Marsha) having difficulty at work with supervisor that she fears may interfere with future promotions**

POST-TRAUMATIC STRESS DISORDER: Treatment

- **COGNITIVE BEHAVIORAL THERAPY (CBT)**
 - **Psychoeducation**
 - **Anxiety Management**
 - **Cognitive Restructuring**
 - **Imaginal and *in-vivo* exposure**
 - **Relapse Prevention**

POST-TRAUMATIC STRESS DISORDER: Treatment

- **PSYCHOEDUCATION**
 - Present patient with information about common symptoms and assess to make sure they understand their particular symptoms
 - Normalize the trauma reaction
 - Establish the rationale for treatment while getting patients verbal commitment to proceed

POST-TRAUMATIC STRESS DISORDER: Treatment

- **PSYCHOEDUCATION**
 - **Strategies for the prevention of future injury**
 - **Self-monitoring of symptoms**
 - **Awareness of limitations**
 - **Contact information**
 - **How and when to ask for help**
 - **How to participate in treatment**

POST-TRAUMATIC STRESS DISORDER: Treatment

- **ANXIETY MANAGEMENT (to gain a sense of mastery over fear and reduce arousal levels)**
 - **Breathing Retraining**
 - **Progressive Muscle Relaxation**
 - **Mindfulness/Centering Prayer**
 - **Self-talk Management**
 - **Discernment**
 - **Grounding**

POST-TRAUMATIC STRESS DISORDER: Treatment

- **COGNITIVE RESTRUCTURING (belief that maladaptive appraisals underlie PTSD symptoms)**
 - “When ever I let someone get close to me they hurt me”
 - “The world is unfair”
 - “I cannot trust anyone”
 - “It was all my fault”
- **ID and evaluate the evidence for negative automatic thoughts**
- **Help evaluate beliefs about the trauma-the self,**

POST-TRAUMATIC STRESS DISORDER: Treatment

- **COGNITIVE RESTRUCTURING**

- **Helps patient accept the reality they did not encode some information during periods of impaired consciousness**
- **Some may experience guilt, anger or fear because of the way they interpret events that occurred during early trauma**
- **Help them use available information to not catastrophize the event**

POST-TRAUMATIC STRESS DISORDER: Treatment

- **IMAGINAL AND *IN-VIVO* EXPOSURE
(Behavioral Exposure)**
 - **Centerpiece of therapy**
 - **Vividly imagine the traumatic episode for
prolonged periods**
 - **VERBALLY**
 - **IN WRITTEN FORM**
 - **VIRTUAL REALITY**
 - **Develop a coherent narrative**

POST-TRAUMATIC STRESS DISORDER: Treatment

- **IMAGINAL AND *IN-VIVO* EXPOSURE**

Exposure-based therapy is based on the premise that extinction learning occurs when the conditioned stimulus is repeatedly presented in the absence of an aversive outcome, thereby facilitating new learning that the stimulus is no longer signaling threat

- ▣ *In-vivo like treating panic with graded exposure or behavioral desensitization*

POST-TRAUMATIC STRESS DISORDER: Treatment

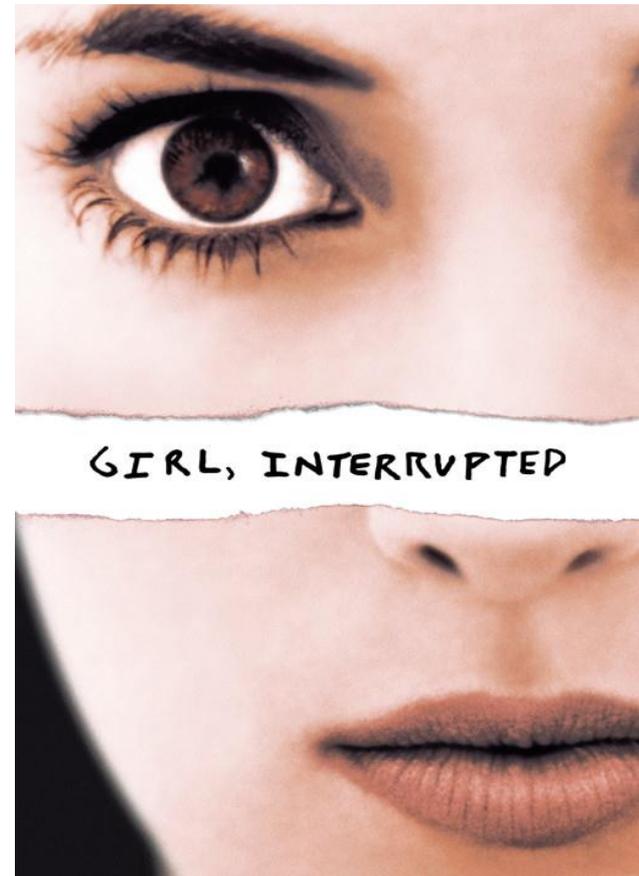
- **RELAPSE PREVENTION**
 - Helping patient deal with residual symptoms as treatment should significantly diminish symptoms but will not make all of them go completely away
 - Example-nightmares and insomnia
 - Develop plans for maintaining abstinence if alcohol and drugs are a problem
 - Develop plans to manage Eating Disorders, gambling and other process addictions
 - On-going personal maintenance plan

BORDERLINE PERSONALITY DISORDER

- **DIALECTICAL BEHAVIOR THERAPY (MARSHA LINEHAN)**
 - **AN INNOVATIVE FORM OF CBT**
 - **HELPS DETECT AND COMBAT DISTORTED THOUGHTS**
 - **COUNTERACT PROBLEMATIC BEHAVIORS AND ASSOCIATED EMOTIONS**
 - ***INCORPORATES MEDITATIVE PRACTICES-MINDFULNESS***
 - ***SELF-SOOTHING TECHNIQUES TO MANAGE MOOD SWINGS (DEEP BREATHING, TAKING WALKS, LISTENING TO MUSIC, ETC.)***
 - **BUILDING HEALTHY RELATIONSHIPS**

Treatment Planning Based on Symptom Clusters

- **Identity Cluster (Projection)**
 - Abandonment fears
 - Unstable self-image
 - Relationship problems
- **Affective Cluster (Splitting)**
 - Reactivity of mood
 - Inappropriate, intense anger
- **Impulsive Cluster**
 - Suicidal behavior
 - Potentially self-harming behavior (substance abuse, sex, binge eating, spending)



MANAGEMENT CONSIDERATIONS

- **Time consuming**
 - Fewer resources
 - Fewer alternative
- **Powerful wishes to create clinician into a friend, lover, parent or enemy**
- **“Therapeutic rupture”**
- **Impulsivity-Limit Setting**
- **Affective Storm-Calmness and Unflappability**
- **Polarization of Thought and Attitude-Integration and Finding Middle Ground**

MANAGEMENT CONSIDERATIONS

- **GOAL**
- **PREREQUISITES**
 - Structure
 - Therapy threatening
 - Life threatening
- **MEDICATION IF NEEDED**
- **BEHAVIORAL**
 - Limit setting
 - Treatment plan
- **CLOSURE**



Identity Cluster

- **Treatment**
 - **Behavioral**
 - Structure
 - Immediate reward
 - **Medication**
 - Neuroleptics
 - SSRI's



Behavioral Foundation Program

TASK	MON	TU	WED	THU	FRI	SAT	SUN
SH							
TX							
FUN							
NUT							
PEX							

Affective Cluster

- **Treatment**
 - **Behavioral**
 - Structure
 - *Setting limits*
 - Fair
 - Consistent
 - Available
 - **Medications**
 - Mood stabilizers
 - Antidepressants



Labeling Our Feelings

- **“We found the more mindful you are, the more activation you have in the right ventrolateral prefrontal cortex and the less activation you have in the amygdala. We also saw activation in widespread centers of the prefrontal cortex for people who are high in mindfulness. This suggests people who are more mindful bring all sorts of prefrontal resources to turn down the amygdala.”**

Labeling Our Feelings

- **Verbalizing our feelings and labeling emotions makes them less intense.**
- **Photograph of an angry or fearful face causes increased activity in the amygdala**
 - Creates a cascade of events resulting in “fight or flight” response
- **Labeling the angry face changes the brain response**

Labeling Our Feelings

- **Labeling the response caused the amygdala to be less active and the right ventrolateral prefrontal cortex to activate.**
- **Using mindfulness and labeling the feelings one experiences allows the prefrontal cortex to override the amygdala.**
 - Matthew Lieberman, UCLA, Psychological Science, May 2007

Impulsive Cluster

- **Self-destructive behavior**
 - **A/D use**
 - **Suicidal and parasuicidal behavior**
 - Hurt self
 - Dissociation
 - Reduce anxiety
 - **Eating disorders**

Non-Suicidal Self Injury

- **Self-injury is reinforced to the extent the behavior is effective (continued)**
 - **Both positive and negative reinforcement**
 - **Negative reinforcement is rewarding by making an unpleasant situation stop**
 - **Positive reinforcement is rewarding by gaining something after the behavior**
- **When negative reinforcement generally relieves uncomfortable emotions like anger, anxiety, guilt and numbness**
- **When positive reinforcement includes “feeling something even if it is pain”, punishing oneself and feeling relaxed**

Non-Suicidal Self Injury

- When positive reinforcement includes “feeling something even if it is pain”, punishing oneself and feeling relaxed (continued)
 - Males more likely to want to “make others angry”
 - Females more likely to want to “punish myself”
- Endogenous Opioids
 - Hypothesized that injury induces the release of endogenous opioids which creates reward
 - B-endorphins comfort negative emotions (Stanley B et al, *J Affect Disord* 2010:124 (1-20:134-140))
 - Early childhood trauma changes the density of opiate receptors and level of B-endorphin baseline

Non-Suicidal Self Injury

- **Early childhood trauma changes the density of opiate receptors and level of B-endorphin baseline (continued)**
 - May find injuring less painful and subsequent opioid release more pleasurable
 - Patients with only one episode of self-injurious behavior say “It hurt” and didn’t repeat behavior
- **Non-suicidal self injury (NSSI) may be the best predictor of suicide attempt (Wilkinson P et al, *Am J Psychiatry* 2011; February 1)**
 - *70% of people who engage in NSSI eventually attempt suicide*

RISK ASSESSMENT

- **SAFETY PLAN**

- Contracting for safety has no evidence base and asking the patient to sign a document stating they will not harm themselves can be problematic
 - Promise without “how to not harm self”
 - May feel they cannot talk about being suicidal
 - May give clinical team a false sense of security
- Develop a plan for “what to do” when patient feels suicidal
- *Safety Planning Intervention (SPI) is a brief intervention with ongoing clinical trial but is a Suicide Prevention Resource Center/American foundation for Suicide Prevention best practice*