



# Intégrer les approches psychiatriques et addictologiques pour les pathologies duelles

Quel beau titre, merci !

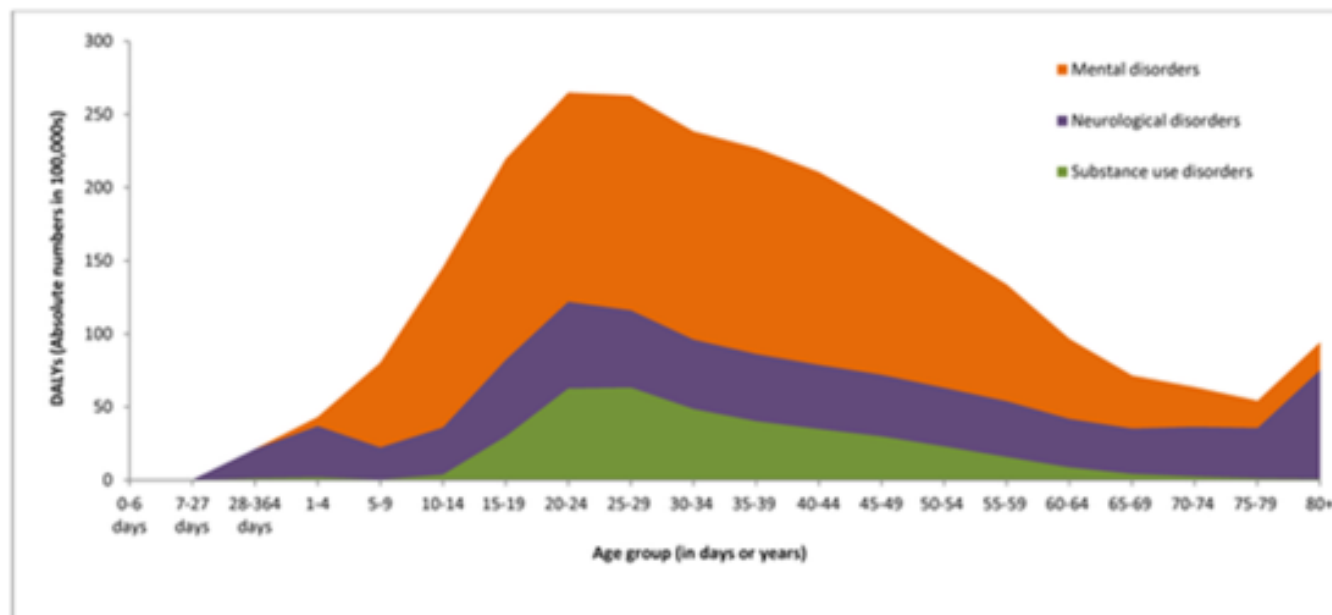
Jean-Michel Delile

Psychiatre, président de la Fédération Addiction

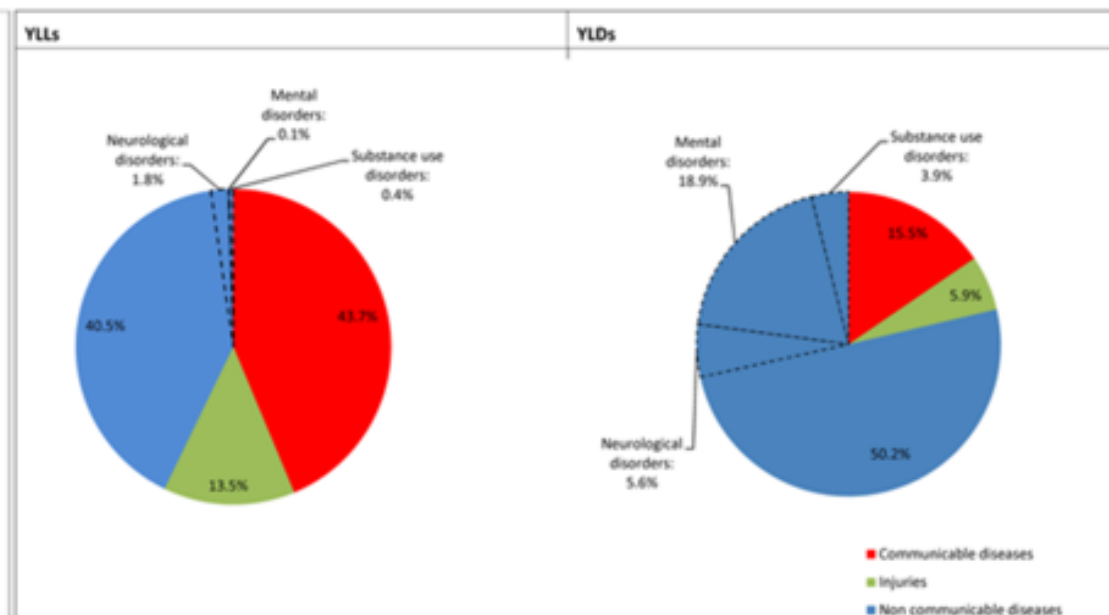
## Absolute DALYs Attributable to Mental, Neurological, and Substance Use Disorders, by Age, 2010.

DALYs = Années de vie ajustées sur l'incapacité (mortalité précoce, maladie, handicap)

# Les troubles mentaux et addictifs : première cause de handicap au monde !



Note: DALYs = disability-adjusted life years.



Note: YLLs = years lost to premature mortality; YLDs = Years lived with disability

Whiteford HA, Ferrari AJ, Degenhardt L, Feigin V, Vos T (2015) *The Global Burden of Mental, Neurological and Substance Use Disorders: An Analysis from the Global Burden of Disease Study 2010*. PLOS ONE 10(2): e0116820. <https://doi.org/10.1371/journal.pone.0116820>

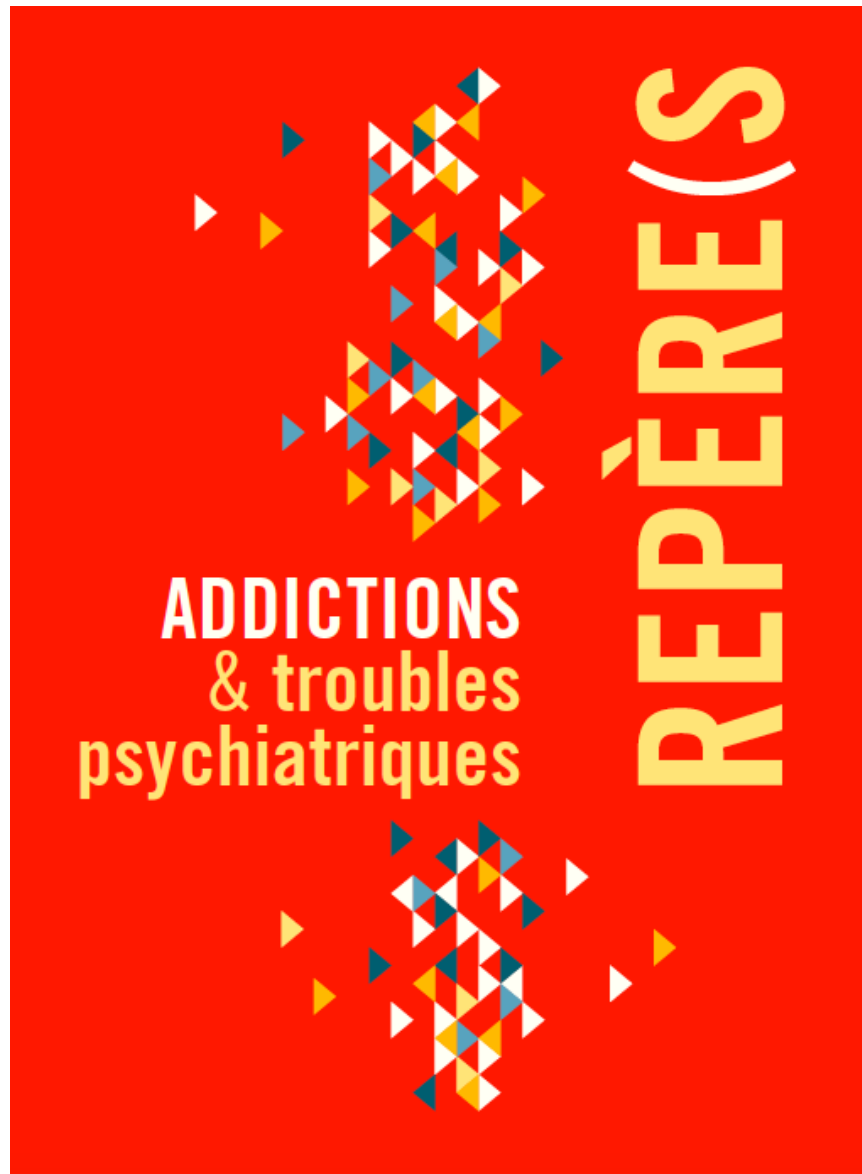
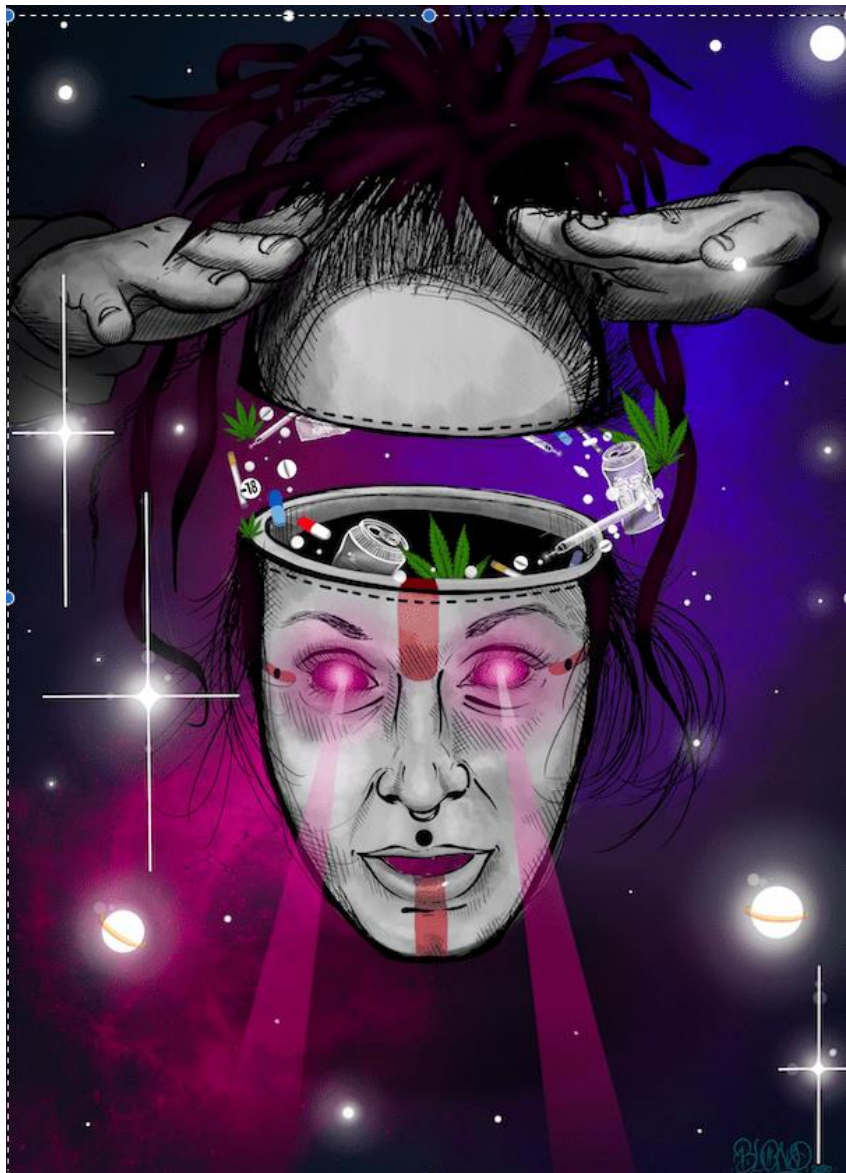
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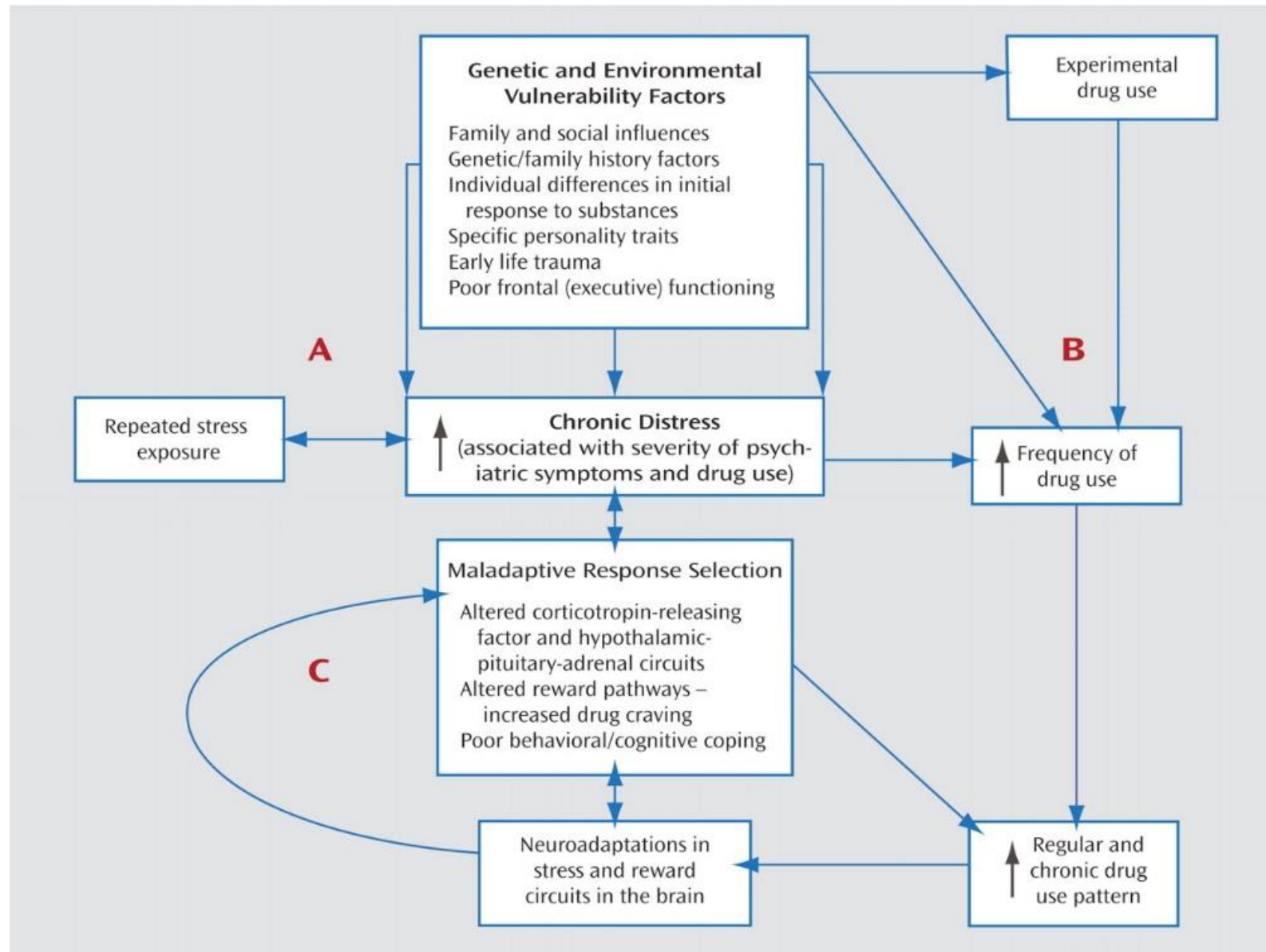


# Pathologies duelles

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- Importantes corrélations
- Intoxication : modèle addictologique (cannabis/psychose)
- Auto-médication : modèle psychiatrique (PTSD/addiction)
- Interactions mutuellement péjoratives
- Pathologies duelles : modèle biopsychosocial
- Causalités communes : « *syndemics* » (PTSD et addictions)
- Nécessité d'actions combinées, intégrées





“Co-Occurring Mental and Substance Use Disorders: The Neurobiological Effects of Chronic Stress”  
Brady & Sinha (Am J Psychiatry 2005; 162:1483–1493)

# De l'usage à l'abus et à l'addiction : la question des différences interindividuelles

Différences dans les  
comportements d'usage de  
substances

Social



Circonstanciel



Intensifié



Compulsif

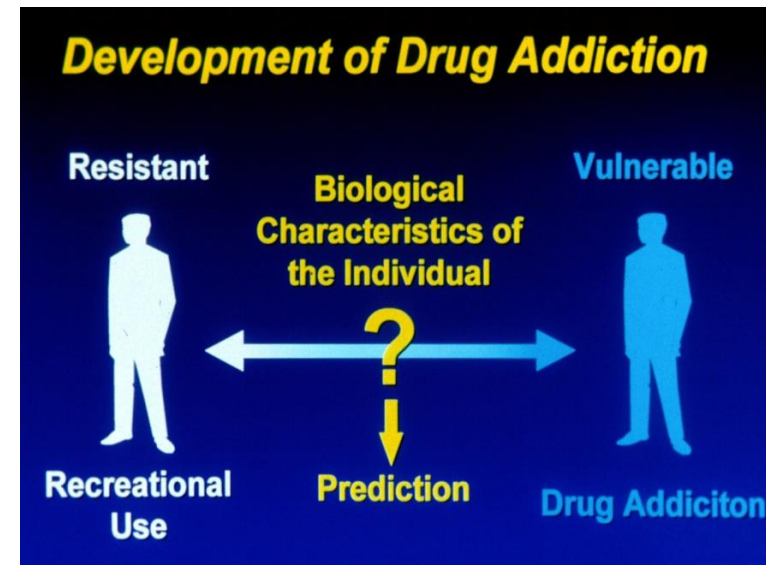


Usage  
Instrumental  
et/ou  
Récréatif



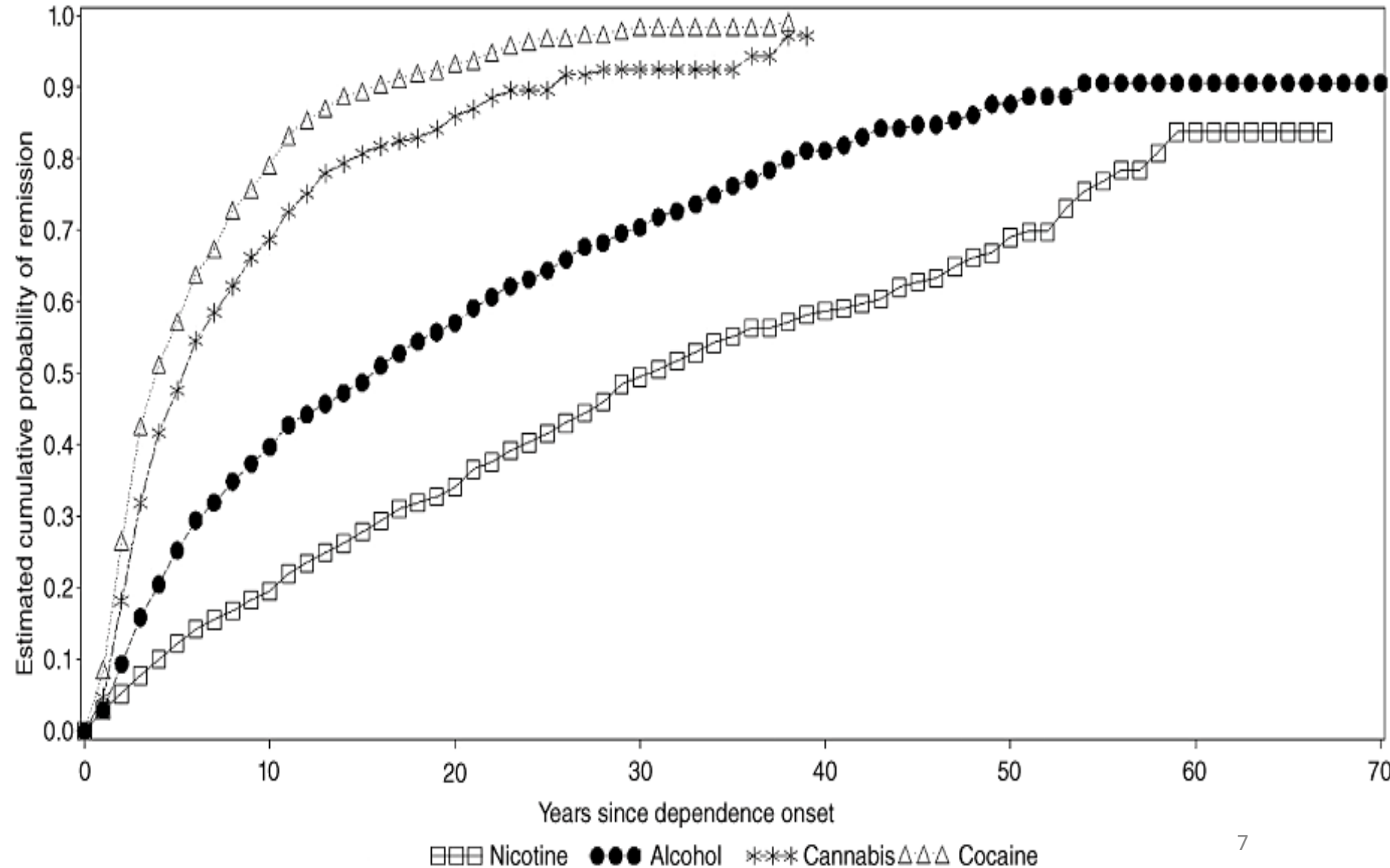
Addiction

Un phénotype  
"Proaddictif" ?



# Probability and predictors of remission from life-time nicotine, alcohol, cannabis or cocaine dependence: results from the National Epidemiologic Survey on Alcohol and Related Conditions

La rémission est presque toujours assurée à un moment de la vie.  
98,92 % des dépendants de la cocaïne présentent au moins un diagnostic de trouble psychiatrique au cours de la vie, en particulier les troubles de la personnalité (et spécifiquement les troubles avec impulsivité, BPD)



Prévalence de comorbidités psychiatriques sur 12 mois chez des personnes présentant un TUS  
(Grant et al. Arch Gen Psychiatry, 2004)

	<b>Humeur</b>	<b>Anxieux</b>	<b>Personnalité</b>
Alcool	27,6 %	23,5 %	39,5 %
Tabac	21,1 %	22,0 %	31,7 %
Drogue	29,2 %	24,5 %	69,5 %



From: **Personality Disorders and the 3-Year Course of Alcohol, Drug, and Nicotine Use Disorders**

Arch Gen Psychiatry. 2011;68(11):1158-1167. doi:10.1001/archgenpsychiatry.2011.136

**Table 2. Relationship of Axis II Disorders to 3-Year Persistence of Substance Use Disorders<sup>a</sup>**

Personality Disorder	Odds Ratio (95% CI)		
	Alcohol Dependence (n=1172)	Cannabis Abuse or Dependence (n=454)	Nicotine Dependence (n=4017)
Antisocial	3.51 (1.74-7.08) <sup>b</sup>	2.46 (1.05-5.73) <sup>c</sup>	3.19 (1.64-6.18) <sup>b</sup>
Avoidant or dependent	0.92 (0.49-1.74)	0.73 (0.29-1.83)	1.02 (0.69-1.51)
Borderline	2.52 (1.64-3.85) <sup>b</sup>	2.78 (1.40-5.50) <sup>d</sup>	2.04 (1.56-2.68) <sup>b</sup>
Histrionic	0.96 (0.57-1.60)	1.10 (0.46-2.65)	1.10 (0.76-1.59)
Narcissistic	1.96 (1.32-2.91) <sup>d</sup>	1.32 (0.63-2.74)	1.22 (0.92-1.61)
Obsessive-compulsive disorder	0.89 (0.57-1.38)	0.91 (0.44-1.87)	1.40 (1.06-1.85) <sup>c</sup>
Paranoid	1.18 (0.72-1.95)	0.83 (0.40-1.73)	0.99 (0.73-1.35)
Schizoid	1.10 (0.59-2.06)	0.80 (0.33-1.97)	1.47 (1.08-2.01) <sup>c</sup>
Schizotypal	3.36 (1.98-5.72) <sup>b</sup>	5.90 (2.68-13.00) <sup>b</sup>	1.65 (1.19-2.28) <sup>d</sup>

<sup>a</sup>Controlling for demographics, Axis I categories listed in Table 1 and the other personality disorders, family history of alcohol or drug problems, current alcohol or drug treatment at baseline, and baseline duration (months) of longest or only use disorder.

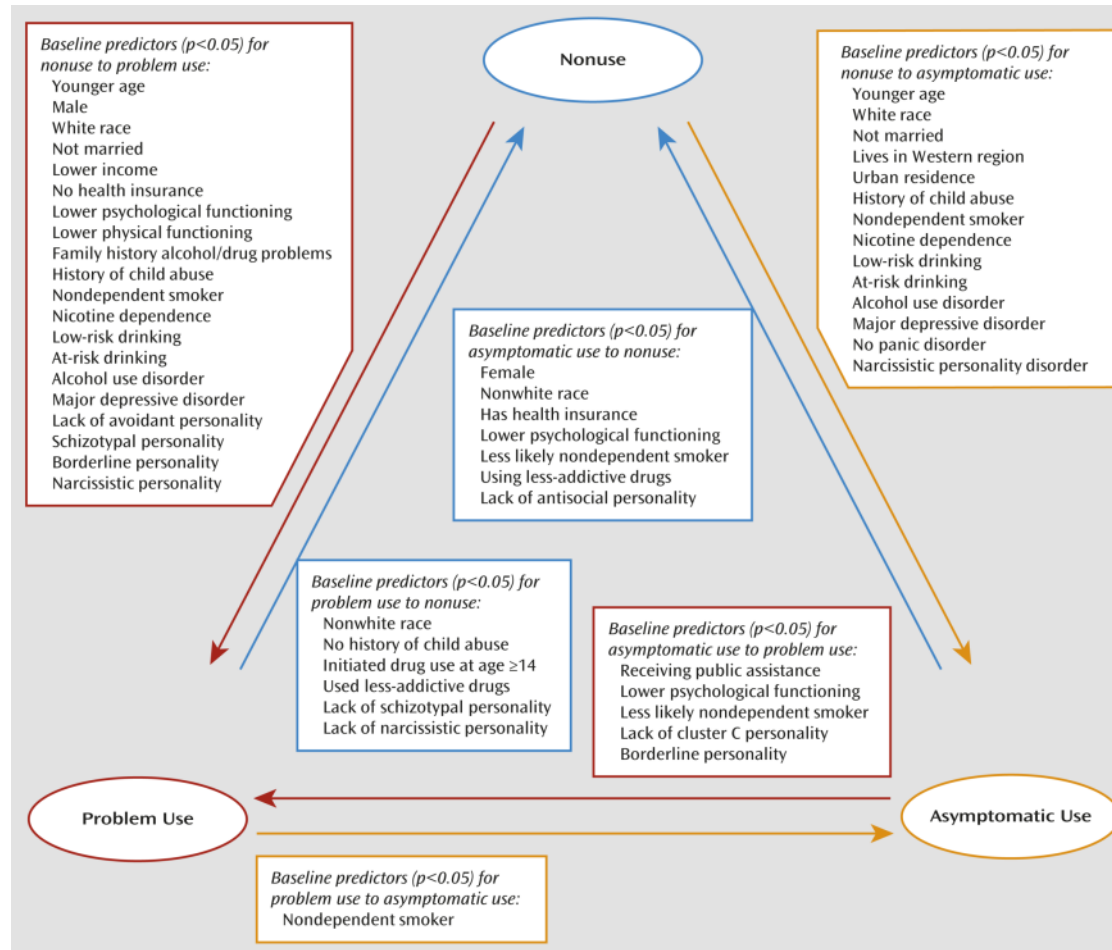
<sup>b</sup> $P < .001$ .

<sup>c</sup> $P < .05$ .

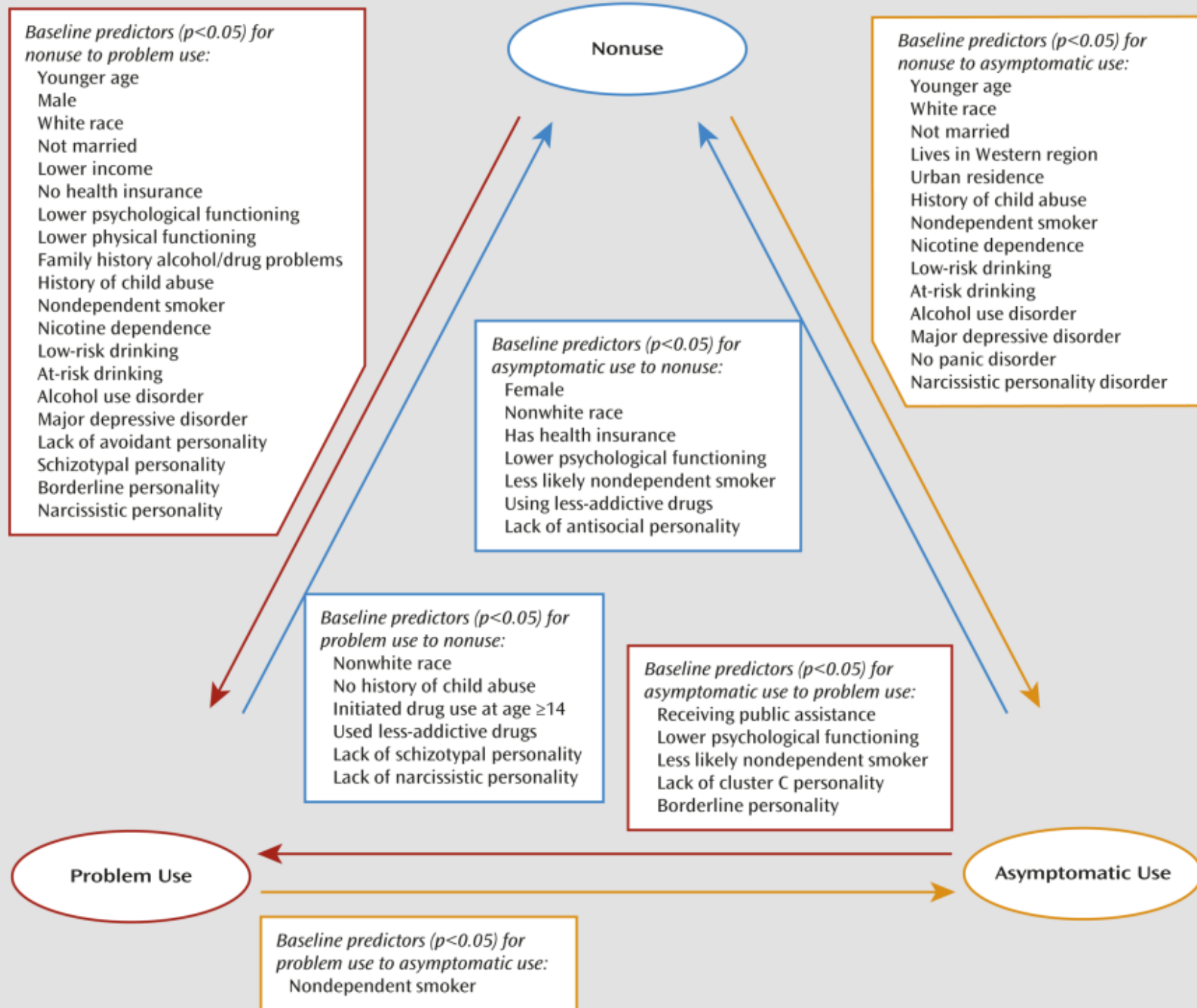
<sup>d</sup> $P < .01$ .

**From: Transitions in Illicit Drug Use Status Over 3 Years: A Prospective Analysis of a General Population Sample**

Am J Psychiatry. 2013;170(6):660-670. doi:10.1176/appi.ajp.2012.12060737

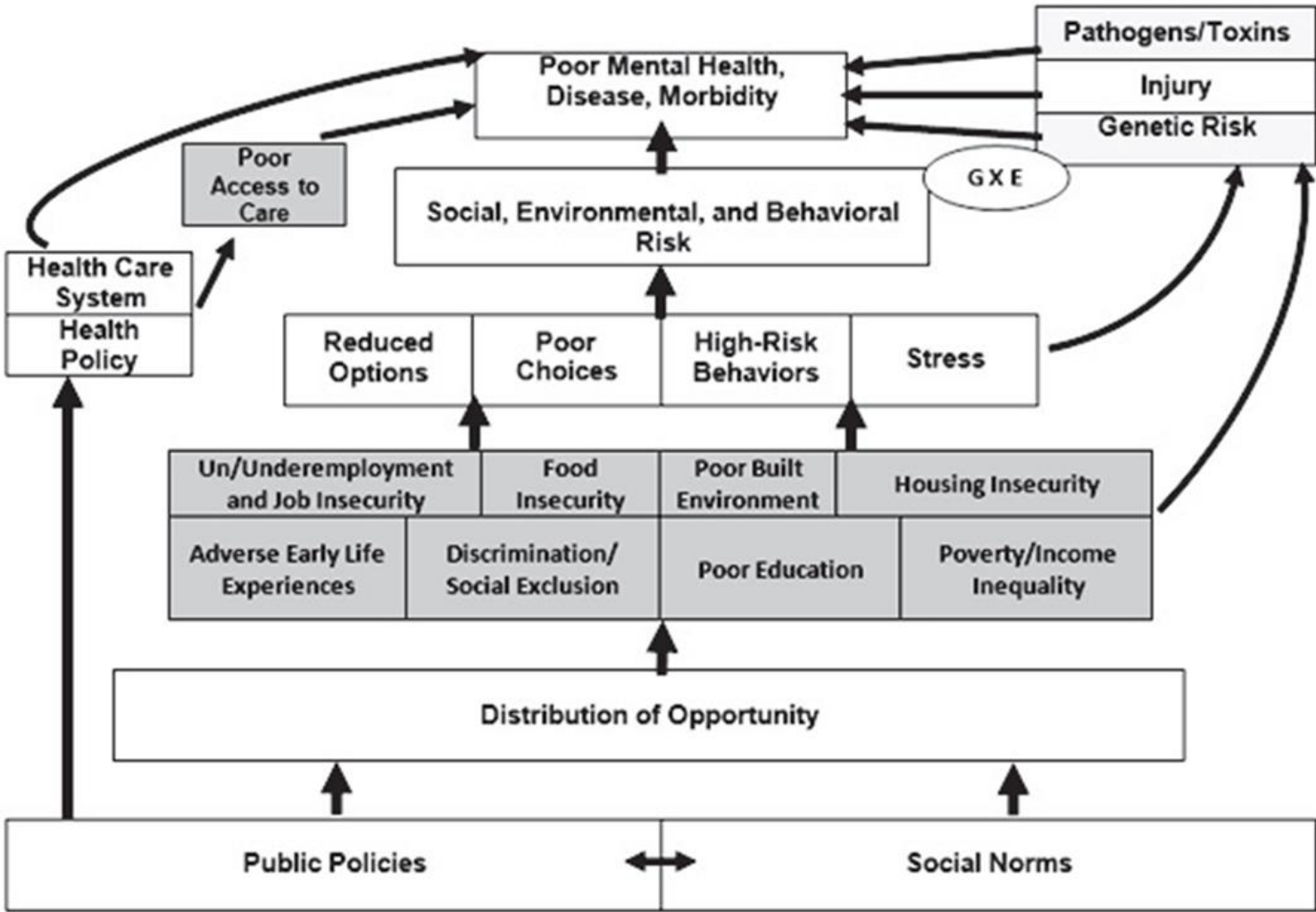


**Modeling Approach to Transitions in Drug Use Status From Baseline to 3-Year Follow-Up Among U.S. Adults Age 18 and Older<sup>aa</sup>**  
Predictors based on reduced multinomial regression models (from Table 3).



The Social Determinants of Mental Health

Michael T. Compton  
Ruth S. Shim.





# Psychotrauma et pathologies duelles, une question centrale

Traumas complexes, troubles de la personnalité, anxiété de séparation...

et addictions :

intérêt d'une approche intégrée

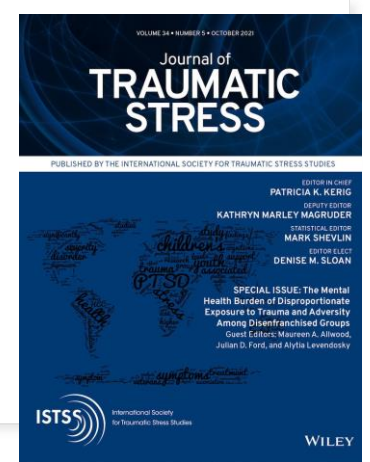
# Anxiété de séparation



- L'étude de Joel Swendsen et al. (*Mental disorders as risk factors for substance use, abuse and dependence: results from the 10-year follow-up of the National Comorbidity Survey*, *Addiction*, 2010, 105, 6, 1117-1128) indique que l'anxiété de séparation est (avec le trouble bipolaire et le TDA/H) un des facteurs psychiatriques les plus puissamment prédictifs de l'initiation à l'usage de drogues et de la transition de l'usage vers l'abus.
- Les troubles des conduites chez l'enfant sont également très déterminants (plus que le TDA/H en lui-même)
- Les modélisations indiquent que le traitement de ces troubles permettrait de prévenir 34,2 % des initiations; 61,5 % des cas d'abus chez les usagers et 72 % des cas de dépendance chez les abuseurs (population-attributable risk proportion, PARP).

# Complex PTSD: A syndrome in survivors of prolonged and repeated trauma

(Judith Lewis Herman, Journal of Traumatic stress, 1992, 5, 3)



- This paper reviews the evidence for the existence of a complex form of post-traumatic disorder in survivors of prolonged, repeated trauma.
- The current diagnostic formulation of PTSD derives primarily from observations of survivors of relatively circumscribed traumatic events. This formulation fails to capture the protean sequelae of prolonged, repeated trauma.
- In contrast to a single traumatic event, prolonged, repeated trauma can occur only where the victim is in a state of captivity, under the control of the perpetrator. The psychological impact of subordination to coercive control has many common features, whether it occurs within the public sphere of politics or within the private sphere of sexual and domestic relations.

# Stress/Addiction :

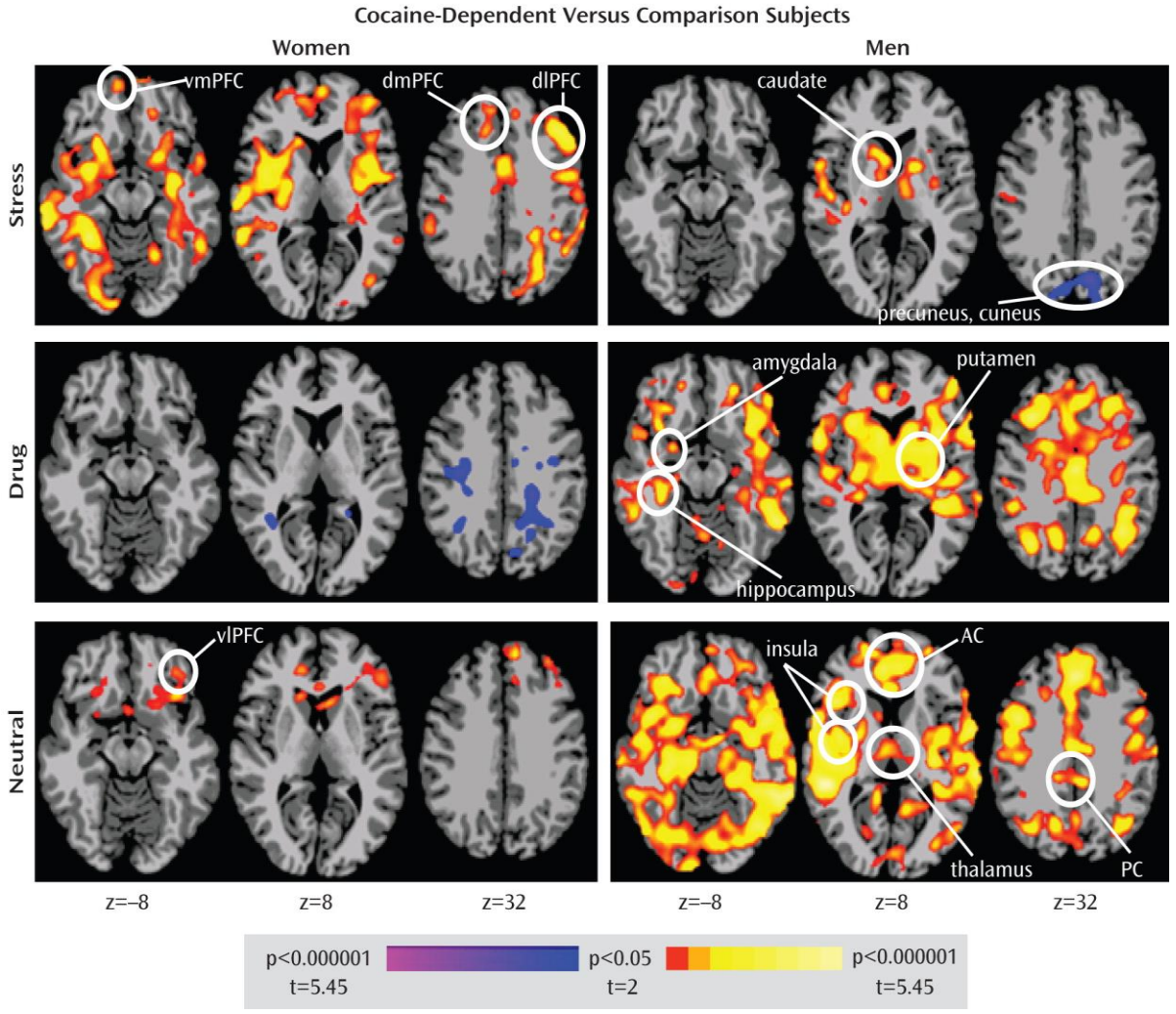
un facteur de risque majeur (transition, maintien, rechute)  
surtout chez les femmes

- Enoch MA: The role of early life stress as a predictor for alcohol and drug dependence. *Psychopharmacology (Berl)* 2011; 214:17–31
- Sinha R, Fox HC , Hong KI, Hansen J, Tuit K, Kreek MJ: Effects of adrenal sensitivity, stress- and cue-induced craving, and anxiety on subsequent alcohol relapse and treatment outcomes. *Arch Gen Psychiatry* 2011; 68:942–952
- Potenza et al: Neural correlates of stress-induced and cue-induced drug craving: influences of sex and cocaine dependence. *Am J Psychiatry* 2012; 169:406–414 :

“In cocaine dependence, corticostriatal-limbic hyperactivity appears to be linked to stress cues in women, drug cues in men, and neutral-relaxing conditions in both. These findings suggest that sex should be taken into account in the selection of therapies in the treatment of addiction, particularly those targeting stress reduction.”



# Neural Correlates of Stress-Induced and Cue-Induced Drug Craving: Influences of Sex and Cocaine Dependence



Images show between-diagnostic-group contrast maps highlighting regions where cocaine-dependent patients showed more activation than comparison subjects (in yellow to red color) and regions where cocaine-dependent patients showed less activation than comparison subjects (in blue to purple color) during the stress, drug, and neutral-relaxing cue conditions for women and men. prefrontal cortex.

# Do Treatment Improvements in PTSD Severity Affect Substance Use Outcomes? (NIDA)

(Denise A. Hien et al. Am J Psychiatry 2010; 167:95-101)

- The purpose of the analysis was to examine the temporal course of improvement in symptoms of posttraumatic stress disorder (PTSD) and substance use disorder among women in outpatient substance abuse treatment.
- **RESULTS:** Subjects exhibiting PTSD response were significantly more likely to transition to global response over time, indicating maintained PTSD improvement was associated with subsequent substance use improvement. Trauma-focused treatment was significantly more effective than health education in achieving substance use improvement, but only among those who were heavy substance users at baseline and had achieved significant PTSD reductions.
- **CONCLUSIONS:** PTSD severity reductions were more likely to be associated with substance use improvement, with minimal evidence of substance use symptom reduction improving PTSD symptoms. Results support the self-medication model of coping with PTSD symptoms and an empirical basis for integrated interventions for improved substance use outcomes in patients with severe symptoms.

# The impact of EMDR and Schema Therapy on addiction severity among a sample of French women suffering from PTSD and SUD

## Abstract

**Objective:** Examining the effects of eye movement desensitization and reprocessing (EMDR) associated with Schema Therapy (ST) on the improvement in symptoms of posttraumatic stress disorder (PTSD) and substance use disorder (SUD) among women in outpatient substance abuse treatment centre.

**Hypothesis:** Reprocessing both traumatic and addiction memories using EMDR associated with Schema Therapy (ST) reduces PTSD symptoms along with alcohol and drug consumption.

**Results:** 1. PTSD symptoms and early maladaptive schemas started to decrease after 8 sessions (EMDR + ST) focused on traumatic memory  
2. Addiction severity and craving started to decrease after 8 additional sessions (EMDR-ST) focused on addictive memory

## Introduction

In a previous study we showed that 6 women with SUD-PTSD and assigned to eight sessions of EMDR focused on traumatic memory showed a significant reduction in PTSD symptoms but not in SUD symptoms (Perez & Tapia, in press). Previous studies engaged in integrated-treatment intervention for SUD showed that:

- early maladaptive schemas underpin psychological problems such as PTSD (Cockram et al., 2010) and SUD (Brothie et al., 2004)
- reprocessing the addiction memory with EMDR decreased craving for alcohol post-treatment (Hase et al., 2008)

## Method

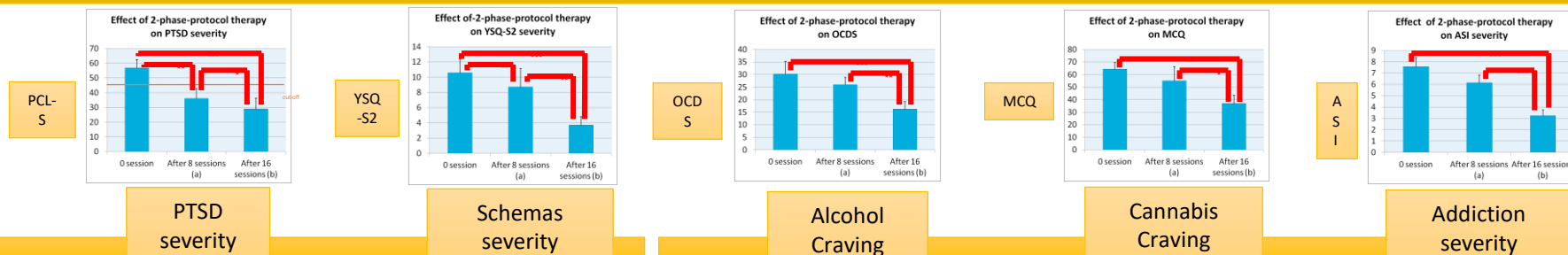
This study investigated in the treatment of SUD among 7 women receiving as usual social and medical care (for 2 years) for resistant addiction problems (polydrug users) in a drug treatment centre in Bordeaux. The selected outpatients met the SUD and PTSD comorbidity according to the DSM-IV diagnostic features for SUD and PTSD (APA, 1994).

We proposed a 2-phase-protocol therapy:

- a: 8 EMDR sessions (traumatic memory) associated with ST (attachment disorder)
- b: 8 EMDR sessions (addictive memory) associated with ST.

We evaluated PTSD symptoms (PCL-S), Early Maladaptive Schemas - EMS(YSQ-S2), alcohol craving (OCDS), cannabis craving (MCQ) and addiction severity (ASI) before and after treatment.

## Results



## Discussion

The present study suggests that reprocessing both traumatic and addiction memories using EMDR procedure associated with ST reduces not only PTSD symptoms and EMS (after 8 sessions) but also craving and addiction severity (after 16 sessions).

These results suggest that co-occurring PTSD symptoms and EMS may have a strong impact on SUD symptoms. Thus, with our study, we enlarge evidence-based support for EMDR and ST as valuable treatments for SUD.

## Conclusion

This study offers integrated treatment to address PTSD and EMS early on in therapy for SUD symptoms. Finally our research reinforces the idea that **integrated-treatment intervention** are needed for improving SUD outcomes (Back, 2010).

## REFERENCES

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- Perez-Dandieu, B., & Tapia, G. (in press). Treating trauma in addiction with EMDR: A pilot study. *Journal of Psychoactive Drugs*.

**Published by:**  
National Center for PTSD  
VA Medical Center (116D)  
215 North Main Street  
White River Junction  
Vermont 05009-0001 USA  
  
(802) 296-5132  
FAX (802) 296-5135  
Email: [ncptsd@va.gov](mailto:ncptsd@va.gov)

All issues of the PTSD Research Quarterly are available online at:  
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## Behavioral Interventions for Comorbid PTSD and Substance Use Disorder

### Prevalence and Associated Problems

Posttraumatic stress disorder (PTSD) and substance use disorders (SUD) often co-occur. According to one national epidemiologic study 46.4% of individuals with lifetime PTSD also met criteria for SUD (Pietrzak et al., 2011). Among Veterans these numbers are even higher, a substantial majority with PTSD have met criteria for comorbid SUD in their life time. The National Vietnam Veterans Readjustment Study, conducted in the 1980s found 74% of Vietnam Veterans with PTSD had comorbid SUD (Kulka et al., 1990). Among treatment seeking Veterans who served in Operations Enduring Freedom (OEF) / Iraqi Freedom (OIF) / New Dawn (OND), 63% of those diagnosed with Alcohol Use Disorder (AUD) or other SUD also had a diagnosis of PTSD (Seal et al., 2011). For those diagnosed with AUD and another SUD, the rate of PTSD diagnosis was 76%.

Although PTSD and SUD (PTSD+SUD) are each associated with functional impairment, on average, individuals who have both disorders have more additional psychiatric and functional problems across multiple domains, including medical, legal, financial, and social (McDevitt-Murphy et al., 2010; Tate et al., 2007). In a nationally representative sample of US Veterans, the co-occurrence of PTSD and AUD was associated with higher rates of attempted suicide (46%) and suicidal ideation (39.1%) when compared to AUD alone (attempts = 4.1%; ideation = 7.0%), and greater suicide attempts when compared to PTSD alone (22.8%) (Norman et al., 2018).

### Behavioral Intervention Research

Historically, treatments for PTSD+SUD were sequential, with SUD treated first, due in part to prevailing, although unsubstantiated concerns that

**Sonya B. Norman, PhD**  
National Center for PTSD, Executive Division  
and University of California San Diego School of Medicine

**Denise A. Hien, PhD, ABPP**  
Center of Alcohol & Substance Use Studies  
Graduate School of Applied and Professional Psychology  
Rutgers University-New Brunswick

patients had to be abstinent from substances in order to effectively address trauma and PTSD symptoms. In addition, it was commonly assumed that patients with SUD who were still using substances were too fragile to deal with trauma memories and PTSD and that doing so may lead to clinical worsening such as relapse or worse use, symptom exacerbation, and increased risk of suicidal intent and behaviors (Becker et al., 1991). At the Department of Veterans Affairs (VA) and in the community, it was common for patients to be turned away from PTSD treatments if they had not achieved some length of abstinence from substances.

Given these concerns, it is not surprising that early efforts to treat PTSD+SUD concurrently or in an integrated fashion (i.e., addressing both PTSD and SUD within one protocol) approached PTSD using present focused, skills based approaches that did not include trauma processing or exposure to trauma reminders (Najavits, 2006; McGovern, 2015). The *Seeking Safety* protocol (Najavits, 2006), was among the first integrated treatments to be studied. *Seeking Safety* is a present centered coping skills therapy that helps patients develop skills in interpersonal, cognitive, and behavioral domains. *Seeking Safety* has been evaluated in over 10 randomized controlled trials with a variety of populations (e.g., women, Veterans) with comparisons that included health education and evidence-based SUD treatments such as relapse prevention (Garland et al., 2016; Hien et al., 2009; Roberts et al., 2015; Schäfer et al., 2019). These studies have generally found that *Seeking Safety* improves PTSD+SUD comparably to comparison conditions and provided the first evidence that PTSD+SUD could be treated in an integrated fashion without clinical worsening. Another skills based model, *Integrated Cognitive Behavioral Therapy for PTSD and SUD*, uses cognitive restructuring and other cognitive behavioral

*Continued on page 2*

strategies to address both PTSD and SUD. Initial studies have shown the treatment to be comparably effective to SUD treatment alone for reducing PTSD symptoms (Capone et al., 2018; McGovern et al., 2015). At the same time, numerous studies demonstrated that the most effective treatments for PTSD-alone were trauma focused psychotherapies (therapies where a primary focus of each session involves processing trauma related memories and distress) (Watts et al., 2013). However, concerns that patients with SUDs could not handle trauma processing continued to be a barrier to comorbid patients receiving such treatments. It was not until the past decade that studies of trauma focused therapies for those with PTSD+SUD begun to emerge in larger numbers. These studies primarily evaluated prolonged exposure (PE) therapy concurrently or integrated with evidence based SUD treatment. In PE, patients process trauma through in-vivo (real life) and imaginal (retelling and listening to recorded accounts of the trauma memory) exposure to trauma reminders. The most studied integrated treatment has been the *Concurrent Treatment of PTSD and Substance Use Disorder Using Prolonged Exposure* (COPE) protocol which blends PE with relapse prevention for SUD. Contrary to beliefs that patients with PTSD+SUD could not handle trauma focused therapies, these studies have shown consistently that PE with SUD treatment as usual leads to better PTSD outcomes, and in some studies better SUD outcomes, than present focused or SUD only treatment (e.g., Norman et al., 2019; Roberts et al., 2015; Ruglass et al., 2017). Mills and colleagues (Mills et al., 2012) compared COPE to SUD treatment in the Australian healthcare system and found that COPE had significantly greater reductions in PTSD symptom severity at the end of nine months post-baseline. Ruglass and colleagues (Ruglass et al., 2017) compared COPE to relapse prevention and to active monitoring in a community sample. Among those with full PTSD, participants who received COPE had better PTSD outcomes than those in the other two conditions.

Three recent studies evaluating PE or COPE with Veterans with PTSD+SUD largely support the community findings. Back and colleagues (Back et al., 2019) compared COPE to relapse prevention among Veterans who served post-9/11 and found that COPE resulted in greater PTSD symptom reduction and greater likelihood of remission. Kehle-Forbes and colleagues (Kehle-Forbes et al., 2019) compared PE integrated with motivational enhancement therapy (MET) to sequential treatment where PE followed MET. Both conditions had clinically and significant reductions in substance use and PTSD symptom severity, but did not significantly differ from each other. The first study to directly compare integrated PE (COPE) to integrated present focused coping skills therapy (*Seeking Safety*) was with a Veteran sample. The study found that improvement in PTSD symptom severity and remission rates were better in the PE condition than in *Seeking Safety* (Norman et al., 2019).

Studies that have looked at processes or symptom change within treatment are helping to inform whether effective PTSD treatment such as PE or COPE should be delayed until substance use is reduced or stopped. Several studies have shown that within treatment for PTSD+SUD, PTSD symptom improvement is associated with greater subsequent substance use improvement, but the reverse relationship (substance use predicting subsequent PTSD symptoms) is not as strong (Hien et al., 2010, 2018; Kaczurkin et al., 2016; Tripp et al., in press), suggesting that effective PTSD treatment should not be delayed.

Studies have also examined whether clinical worsening (e.g., PTSD or depression symptom exacerbation, increased substance use, increased suicidal ideation) occurs when exposure is first initiated in COPE (Lancaster et al., 2020; Tripp et al., 2020). These studies have shown low rates of clinical worsening overall and that worsening rates were no higher in COPE than in the control condition (relapse prevention in one study, *Seeking Safety* in the other). These studies further document that introducing exposure is not adverse to comorbid PTSD+SUD patients, even in the short term when patients first initiate imaginal exposure. No evidence from these studies shows worsening of substance use or other adverse events in patients who have received trauma processing treatments, even while using up to 4 times per week (i.e., Hien et al., 2018). Taken together, these findings underscore that treating PTSD effectively using PE or COPE is important to both PTSD and SUD outcomes and serve to contradict fears and unsubstantiated beliefs that effective PTSD treatment should be delayed until improvement in substance use is achieved.

Other evidence-based trauma focused treatments for PTSD such as Cognitive Processing Therapy (CPT) and Eye Movement Desensitization and Reprocessing (EMDR) have thus far been less studied for comorbid PTSD+SUD, although early results are promising and generally follow the findings reported on PE above demonstrating positive direct impacts on PTSD and well tolerated trauma processing with respect to SUD outcomes and treatment dropout. A retrospective chart review of Veterans who had received at least one session of CPT showed that Veterans with and without current and past alcohol use disorder did not differ in number of sessions attended and all showed PTSD symptom reduction (Kaysen et al., 2014). In a sample of 73 American Indian/Native American women with full or subthreshold PTSD and recent alcohol or substance use, a culturally modified version of CPT led to greater reductions in PTSD symptoms and substance use than six weeks of waitlist control (Pearson et al., 2019). **A small pilot study of 12 participants showed that patients randomized to EMDR plus SUD treatment as usual showed greater PTSD symptom reduction than those randomized to SUD treatment as usual only (Perez-Dandieu & Tapia, 2014).** Further studies of CPT and EMDR with randomized controlled trial designs are critical as these trauma focused therapies are highly recommended for the treatment of PTSD in all (in the case of CPT) or most (in the case of EMDR) clinical practice guidelines for the treatment of PTSD (Hamblen et al., 2019).

### Promising Directions and Gaps

Research over the past decade has moved the field of treating comorbid PTSD+SUD forward significantly, especially the documented effectiveness of PE concurrent or integrated with evidence based SUD treatment. However, many gaps and questions remain about how best to treat this comorbidity. While PE offered concurrently with SUD treatment is more effective than other treatment options for PTSD+SUD, attendance at any treatment among patients with PTSD+SUD is often low, treatment dropout in general is high, and effect sizes for PE for PTSD+SUD are smaller than in studies of PE for primary PTSD. A meta-analysis of PTSD+SUD treatment studies found dropout to range between 50 and 70% (it is important to note that this meta-analysis included early studies that included highly modified exposure protocols). While in PTSD treatment studies effect sizes for PE are generally large (Watts et al., 2013), for studies of

# From: Substance Use Disorders in Patients With Posttraumatic Stress Disorder: A Review of the Literature

(Jacobsen et al. American Journal of Psychiatry 2001)

PTSD Symptoms of Increased Arousal	Symptoms of CNS Depressant Withdrawal
Difficulty falling or staying asleep	Insomnia
Irritability or outbursts of anger	Psychomotor agitation
Difficulty concentrating	Anxiety
Hypervigilance	Autonomic hyperactivity
Exaggerated startle response	Increased hand tremor
	Transient hallucinations
	Nausea or vomiting
	Seizures

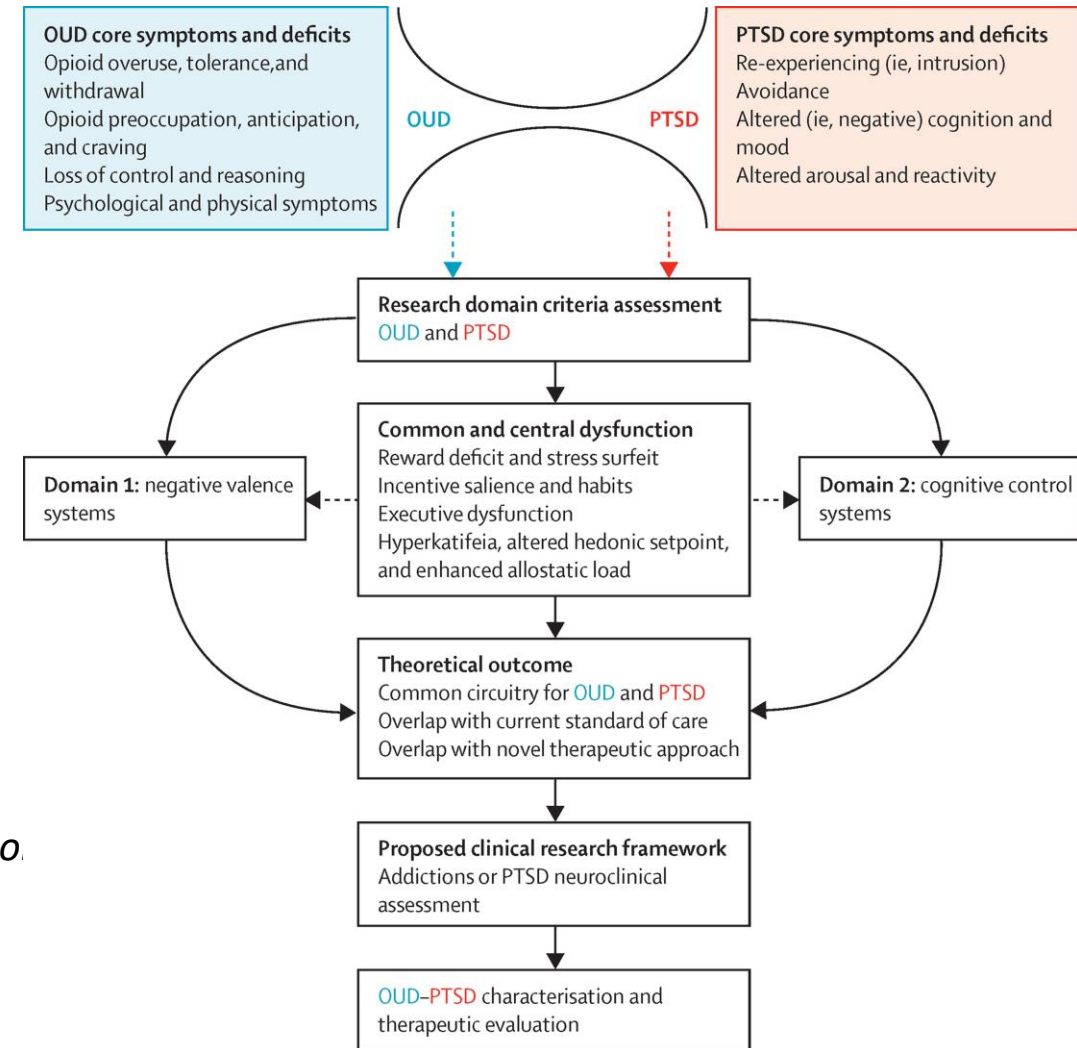
From the DSM-IV criteria for PTSD, alcohol withdrawal, and sedative, hypnotic, or anxiolytic withdrawal.

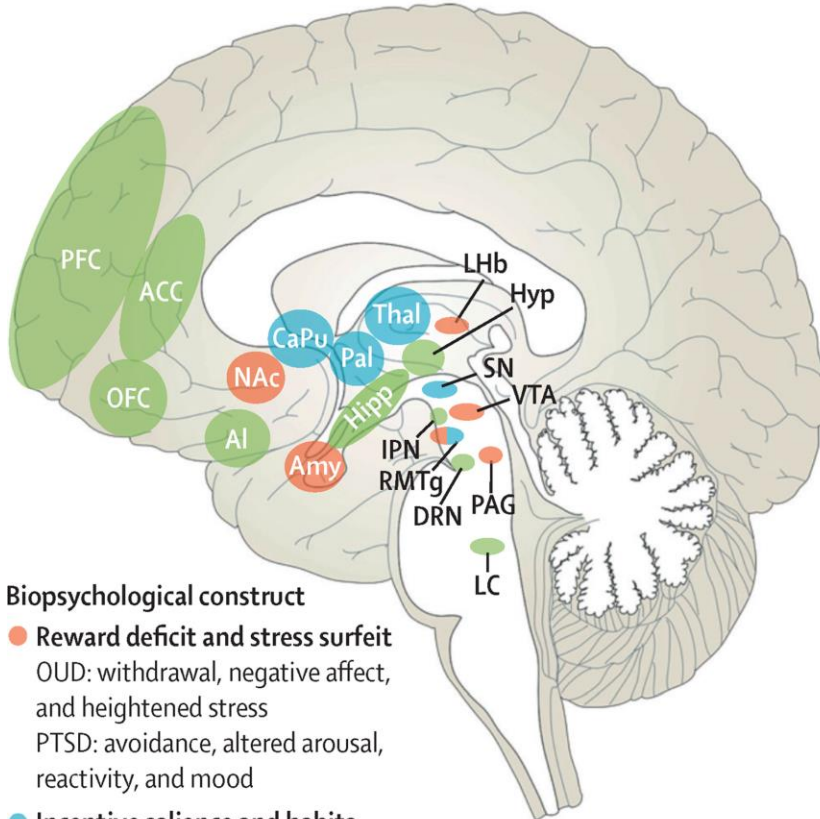
# OUD/PTSD Overlap

*Neurocircuitry basis of the opioid use disorder–post-traumatic stress disorder comorbid state: conceptual analyses using a dimensional framework*

Jaymin Upadhyay, ..., George F Koob and Rudy Schreiber

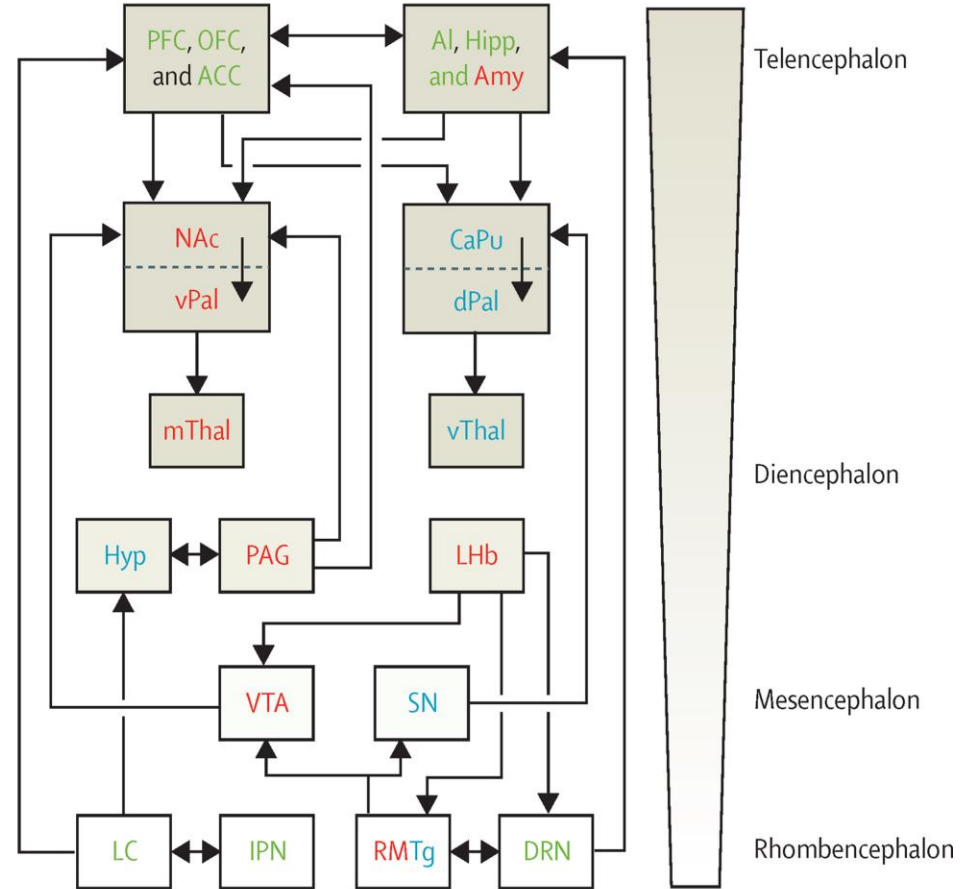
The Lancet Psychiatry, 2022, 9, 1: 84-96





**Biopsychological construct**

- **Reward deficit and stress surfeit**  
 OUD: withdrawal, negative affect, and heightened stress  
 PTSD: avoidance, altered arousal, reactivity, and mood
- **Incentive salience and habits**  
 OUD: intoxication  
 PTSD: avoidance, altered arousal, reactivity, and mood
- **Executive dysfunction**  
 OUD: preoccupation and expectancy  
 PTSD: re-experiencing, avoidance, and altered cognition



Upadhyay et al, The Lancet Psychiatry, 2022, 9, 1: 84-96



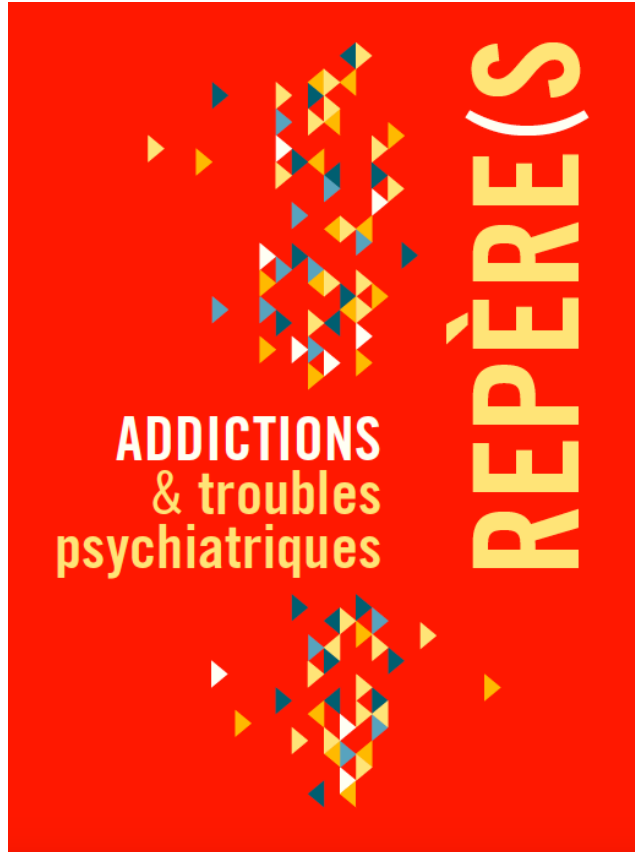


# Améliorer le repérage, l'accès aux soins et leur continuité

Pour faire face aux pathologies duelles  
Un exemple d'action : projet FA/CN2R

# Présentation du projet PsychoTraumAddicto

# Projet « Addictions et Troubles Psychiatriques » de la Fédération Addiction



- Démarche participative 2016-2019 => Publication du guide
- Organisation de journées à l'échelle régionale et nationale => Journée du 16 mars en présence du Ministre des Solidarités et de la Santé (1 660 inscrits)
- Formation continue psychotraumatismes et addictions.

# Carte d'identité du projet

- Fonds de lutte contre les addictions, AAP « Mobilisation de la société civile » 2020 (CNAM)
- Un projet sur 3 ans : 2021-2023
- Co-référents : Dr Jean-Michel Delile (CEID-Addictions, Président de la Fédération Addiction), Pr Georges Brousse (CHU de Clermont-Ferrand)
- Partenaires : CN2R, CHU de Clermont-Ferrand.



# Objectif et enjeux du projet

## **Objectif :**

Améliorer le repérage et l'accompagnement des troubles addictifs et TSPT co-occurents.

## **Enjeux :**

- Co-occurrence forte entre TUS et TSPT - diagnostics aggravés ;
- Développement de 12 Centres régionaux du psychotraumatisme + antennes locales sur le territoire ;
- Amélioration des outils de repérage et d'accompagnement disponibles ;
- Défaut d'interconnaissance et de coordination CSAPA/CRP et défaut de repérage et d'accompagnement adapté.

*Une modalité de travail conjoint pour penser un protocole de repérage et d'accompagnement adapté aux besoins.*



# Acteurs du projet

## **Acteurs en présence :**

- 9 CSAPA sélectionnés sur 3 sites => 1 binôme par CSAPA
- 3 Centres régionaux du psychotraumatisme sur ces mêmes sites => 1 binôme par CRP.

## **Instances partenariales et institutionnelles du projet :**

- Comité de suivi en charge de l'ingénierie
- Comité de pilotage
- Comité scientifique pour élaborer les kits d'intervention et de formations croisées
- Une équipe d'évaluation => CHU de Clermont-Ferrand.



# Les étapes du projet

Calendrier 2022-2023			
		2022	2023
Janvier		3 réunions site (janvier + février)	1 réunion CS
Février		1 réunion CS	Finalisation rédaction 2 kits (février + mars)
Mars		Elaboration trame 2 kits (mars + avril)	
Avril			Envoi version finale 2 kits + intégration retours
Mai		Envoi trame 2 kits + intégration retours	1 réunion COFIL + 6 journées formation site (mai + juin)
Juin		1 réunion CS	
Juillet		Rédaction des 2 kits (juillet + août)	Graphisme + impression + diffusion 2 kits
Août			
Septembre		1 réunion COFIL	3 réunions site (septembre + octobre)
Octobre		Envoi + intégration des retours	
Novembre		3 réunions site (novembre + décembre)	3 webinaires (novembre + décembre)
Décembre			
Ajouter : évaluation			



# Conclusions :

## Le repérage des pathologies duelles du point de vue des addictions

- Repérer des vulnérabilités en amont : non seulement facteurs causaux mais aussi facteurs d'entretien, d'aggravation et de récurrence
- Repérer des complications psychiatriques en aval
- Urgente nécessité de formation au repérage et à l'accompagnement
- Décloisonnement des filières de formation et de prises en charge
- (co)formations croisées, (re)créer une culture commune !
- Échange de stagiaires
- Équipes mixtes
- Ex : Prépsy ou coportage projet PsychoTraumAddicto
- Approche intégrée !



FÉDÉRATION  
**ADDICTION**  
Prévenir | Réduire les risques | Soigner

Merci  
pour votre  
attention !



"Do you want the real remedy?  
STOP CHASING CATS!"