

Regular article

Exposure therapy in the treatment of PTSD among cocaine-dependent individuals: description of procedures

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Abstract

An estimated 30% to 50% of cocaine-dependent individuals meet criteria for lifetime PTSD. This comorbidity has detrimental effects on clinical presentation, and treatment course and outcome. Cocaine dependence is associated with increased rates of exposure to trauma, more severe symptoms, higher rates of treatment attrition and retraumatization, and greater vulnerability to PTSD when compared to other substance use disorders. These associations underscore the need for effective treatments that address issues particular to PTSD in a manner tolerable to cocaine-dependent individuals. This article describes a manualized psychotherapy developed specifically for individuals with PTSD and cocaine dependence. Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD) provides coping skills training, cognitive restructuring techniques, and relapse prevention strategies to reduce cocaine use. In-vivo and imaginal exposure therapy techniques are incorporated to reduce PTSD symptom severity. Primary treatment goals include psychoeducation specific to the interrelationship between PTSD and cocaine dependence, and clinically meaningful reductions in cocaine use and PTSD symptomatology. Secondary goals include a reduction in HIV high-risk behaviors and improved functioning in associated areas, such as anger and negative affect management. © 2001 Elsevier Science Inc. All rights reserved.

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1. Introduction

The estimated prevalence rates of posttraumatic stress disorder (PTSD) among cocaine-dependent individuals are higher than in the general population and are among the highest of any substance-dependent group. Recent investigations involving clinical samples estimate that approximately 45% of cocaine-dependent individuals meet criteria for lifetime and 18% to 24% for current PTSD (Brady, Dansky, Sonne, & Saladin, 1998; Dansky, Byrne, & Brady, 1999; Najavits, Gastfriend, Barber, Reif, & Muenz, 1998a). These reported rates are much higher than that of the general population lifetime PTSD estimate of 7.8% (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Data from the

Epidemiologic Catchment Area study (Cottler, Compton, Mager, Spitznagel, & Janca, 1992) reveal that, in comparison to other substance use groups (i.e., hallucinogens, marijuana, alcohol), cocaine/opiate users report higher rates of exposure to traumatic events, are more vulnerable to developing PTSD after exposure, and experience more severe symptoms and social impairment. Comorbid PTSD among treatment-seeking, cocaine-dependent samples is associated with more severe symptom profiles, higher rates of Axis II character pathology, and greater risk for revictimization (Back et al., 2000b; Brady, Dustan, Grice, Dansky, & Kilpatrick, 1995; Dansky, Brady, & Saladin, 1998; Najavits, Weiss, Shaw, & Muenz, 1998b).

Comorbid PTSD not only affects clinical presentation but also exerts substantial influence on treatment service utilization, course, and outcome of substance-dependent individuals (Brown, Recupero, & Stout, 1995; Brown, Stout, & Mueller, 1999; Najavits, Weiss, & Shaw, 1999; Ouimette, Brown, & Najavits, 1998; Ruzek, Polusny, & Abueg, 1998;

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Triffleman, Carroll, & Kellogg, 1999). Substance-dependent individuals with PTSD (SUD-PTSD), in comparison to those without PTSD (SUD-only), have been found to be at greater risk for relapse (Brown, Stout, & Mueller, 1996), drink significantly more drinks per drinking day (12.1 vs. 2.6 drinks; Brown & Stout, 1997), and have significantly more heavy drinking days (Brown & Stout, 1997; c.f., Ouimette et al., 1998). SUD-PTSD individuals evidence greater psychological, psychosocial, and occupational impairment during follow-up periods and report a greater number of hospital overnight stays for addiction treatment than do SUD-only individuals (Brown et al., 1999; Ouimette, Finney, & Moos, 1999). In spite of these issues, systematic development and study of treatment for this comorbid population has been largely neglected.

There have been several recent studies of the treatment of PTSD and substance use disorders (SUDs). Najavits et al. (1996; in press-a) have developed an impressive treatment, *Seeking Safety*, that combines cognitive-behavioral and interpersonal therapy techniques for patients with various SUDs and PTSD; it has been tested in group format with women (Najavits et al., 1998b) and is currently undergoing further empirical testing. Triffleman et al. (1999) designed an individual, cognitive-behavioral treatment for men and women with SUDs and PTSD which includes in-vivo, but not imaginal, exposure techniques. These psychotherapies have offered insights and shown promising preliminary results. This article describes a manualized psychotherapy for the treatment of PTSD and cocaine dependence that was designed as a part of a NIDA-funded psychotherapy development trial. One of the unique features of this treatment is the inclusion of imaginal exposure therapy techniques to treat PTSD among cocaine-dependent individuals.

2. Methods and materials

2.1. Overview and goals

Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD) consists of 16 individual 90-minute sessions conducted twice weekly. The 16-session format was chosen to parallel previously tested manualized treatments and to allow for the inclusion of topics deemed important for this dually diagnosed patient population. CTPCD is a cognitive-behavioral therapy suitable for mixed genders and inpatient and outpatient populations. The main impetus for the development of CTPCD was the critical need for an effective psychotherapy that addresses issues particular to PTSD in a manner tolerable to patients also struggling with cocaine dependence. CTPCD represents a synthesis of empirically validated and efficacious cognitive-behavioral treatments for substance dependence (Carroll, 1998; Project MATCH, 1997) and PTSD (Foa, Rothbaum, Riggs, & Murdock, 1991; Foa & Rothbaum, 1998). In CTPCD,

patients receive psychoeducation pertaining to the interconnectedness of PTSD and cocaine dependence, and the underlying principles of cognitive and exposure-based therapies. Coping skills training, relapse prevention techniques, and cognitive restructuring are employed to promote cocaine abstinence. In-vivo and imaginal exposure therapy techniques are applied to reduce PTSD symptom frequency and intensity, particularly phobic avoidance and intrusive thoughts (Foa et al., 1991; Richards & Rose, 1991; Richards, Lovell, & Marks, 1994).

The primary goals of CTPCD are to (1) educate patients about the functional relationship between cocaine dependence and PTSD; (2) initiate and maintain cocaine abstinence; and (3) decrease PTSD symptom severity. Secondary goals include (1) educating patients on the interrelationship between cocaine dependence, PTSD, and HIV; and (2) reducing HIV high-risk behaviors. Throughout treatment, CTPCD attends to these focal areas and associated areas known to be problematic for this dually diagnosed group (e.g., management of negative affect and anger, assertiveness, problem-solving).

2.2. The use of exposure-based therapies in SUD populations

Numerous investigations have documented the efficacy of in-vivo and imaginal exposure therapy for PTSD patients (Boudewyns & Hyer, 1990; Cooper & Clum, 1989; Foa et al., 1999; c.f., Foa & Meadows, 1997; Foa et al., 1991; Keane, Fairbank, Caddell, & Zimering, 1989; Keane & Kaloupek, 1982; Richards & Rose, 1991). However, the use of exposure therapy techniques to treat PTSD in SUD patients has been a focus of much controversy and, as yet, no psychotherapy trials in SUD-PTSD patients have included imaginal exposure techniques. The reluctance to empirically investigate the efficacy of certain exposure-based therapies among SUD-PTSD patients is based, in part, on the belief that imaginal exposure is too emotionally overwhelming for SUD patients who are frail and vulnerable to relapse (c.f., Abueg & Fairbank, 1992; c.f., Triffleman et al., 1999). It is also believed by some that SUD patients are too cognitively impaired for imagery procedures (Abueg & Fairbank, 1992; Pitman et al., 1991). Because of this, the use of imaginal exposure in individuals with PTSD and cocaine dependence has not been explored in a systematic manner. The findings from uncontrolled case studies reveal mixed results (Fairbank & Keane, 1982; Keane & Kaloupek, 1982; Mueser & Butler, 1987; Pitman et al., 1991; Vaughan & Tarrier, 1992).

Given the demonstrated treatment effectiveness of imaginal exposure therapy among PTSD patients and the lack of effective treatments for SUD-PTSD patients, empirical investigation of imaginal exposure as a potential treatment in SUD-PTSD patients is reasonable. Certainly, as with any other form or psychosocial or pharmacologic treatment for

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