



A controlled examination of two coping skills for daily alcohol use and PTSD symptom severity among dually diagnosed individuals



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ABSTRACT

Investigations of targeted coping skills could help guide initial treatment decisions for individuals with co-occurring posttraumatic stress disorder (PTSD) and alcohol dependence (AD) who often endorse worse coping skills than those with AD but not PTSD. Although improvement in coping skills is associated with enhanced alcohol use outcomes, no study has evaluated the utility of teaching specific coping skills in the context of comorbid PTSD/AD. We compared the effects of teaching two coping skills (cognitive restructuring [CR] and experiential acceptance [EA]) or an attention control condition on drinking and PTSD symptoms among 78 men and women with comorbid PTSD/AD during a 5-week daily follow-up assessment. Both CR and EA skills were associated with decreased drinking compared to control, and that change in drinking over time did not significantly differ between those who received CR and EA. Individuals who received CR skills, however, consumed less alcohol on a given day than those who received EA skills. Neither CR nor EA was associated with a decrease in PTSD symptom severity. These results provide preliminary support for clinicians to prioritize CR and EA skills during initial treatment sessions when working with individuals with PTSD/AD, and offer ideas for continued investigation and intervention refinement.

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Posttraumatic stress disorder (PTSD) and alcohol use disorders frequently co-occur (Kessler et al., 1997; DSM-III-R criteria were used). Recent data from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) found that the lifetime prevalence of PTSD/AD comorbidity in the U.S. is 1.6% (Blanco et al., 2013; DSM-IV criteria were used). Compared with those with only PTSD and only AD, those with comorbid PTSD/AD reported greater childhood adversity, higher rates of other Axis I and Axis II disorders, more suicide attempts, and met more diagnostic criteria for each of the two disorders (Blanco et al., 2013). Comorbid PTSD/AD individuals also reported greater disability and treatment seeking than those with AD only (Blanco et al., 2013; Drapkin et al., 2011), as well as worse coping strategies (Ouimette, Brown, & Najavits, 1998). These findings highlight the

need for interventions to address both PTSD and AD among these individuals.

Difficulty tolerating distress and regulating emotions has also been associated with PTSD and alcohol use disorders (McDermott, Tull, Gratz, Daughters, & Lejuez, 2009; Tull, Barrett, McMillan, & Roemer, 2007). A hallmark feature of these difficulties is a lack of engagement in adaptive coping strategies when faced with distress or aversive emotional experiences. Instead, patterns of avoidant coping are often present and may be driven by the inability or unwillingness to experience negatively evaluated thoughts, feelings, sensations, and memories (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Avoidant coping strategies have been found to play an important role in the comorbidity between PTSD and AD (Hruska, Fallon, Sponster, Sledjeski, & Delahanty, 2011). Consistent with the self-medication hypothesis, individuals may consume alcohol as an avoidant coping strategy in response to PTSD-related distress or increased PTSD symptom severity (Kaysen et al., 2014; Simpson, Stappenbeck, Luterek, Lehavot, & Kaysen, 2014). In addition, expectations or beliefs that the effects of alcohol will

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relieve one's PTSD symptoms has been associated with increased alcohol consumption and alcohol-related consequences (Vik, Islam-Zwart, & Ruge, 2008). These results highlight the importance of increasing the use of adaptive coping skills among individuals with comorbid PTSD/AD.

Overview of psychotherapy for comorbid PTSD and alcohol and drug use disorders

Despite the pressing need for effective interventions to address the common and debilitating comorbidity between PTSD and alcohol and drug use disorders, the current evidence base to guide optimum treatment planning for these patients is limited. Although there are three recent narrative reviews of the relevant psychotherapy literature (Berenz & Coffey, 2012; McCauley, Killeen, Gros, Brady, & Back, 2012; van Dam, Vedel, Ehring, & Emmelkamp, 2012) and a meta-analysis (Torchalla, Nosen, Rostam, & Allen, 2012), they were all published in 2012 and summarize roughly the same literature. Taken together, they indicate that non-trauma focused cognitive behavior therapy (CBT) interventions tailored to address both PTSD and substance use disorders do not confer added benefit when compared with standard substance use disorder interventions either with regard to substance use outcomes or PTSD. There was some indication across the reviews and more recent papers that trauma-focused interventions confer benefit in terms of reduced PTSD, though generally not reduced substance use behaviors, relative to control conditions (see also Foa et al., 2013; Mills et al., 2012; Sannibale et al., 2013). One challenge with these studies is that drop-out rates across interventions for those with PTSD/AD are quite high, with as many as 45% of participants dropping out of treatment in some cases (Foa et al., 2013). Thus, many patients are at risk of failing to persist in treatment long enough to be receive effective intervention elements.

In light of the high rates of early treatment drop-out among these patients (Foa et al., 2013; Mills et al., 2012; Read, Brown, & Kahler, 2004; Sannibale et al., 2013), evaluations of specific coping skills to improve PTSD or substance use outcomes early in treatment could be especially valuable. Indeed, in the larger psychotherapy literature, it is very common for adults who begin a course of psychotherapy to fail to return for a second visit (Hamilton, Moore, Crane, & Payne, 2011; Simon, Imel, Ludman, & Steinfeld, 2012; Simon & Ludman, 2010). Most of the interventions developed for those with comorbid PTSD/AD population are quite lengthy, which can be challenging with such high drop-out rates. For example, the Seeking Safety protocol (Najavits, 2004; Najavits, Weiss, Shaw, & Muenz, 1998) is comprised of 25 modules, many of which need to be delivered over two or more sessions, and a recent study by Foa et al. (2013) consisted of 18 sessions of Prolonged Exposure along with the same number of supportive counseling sessions that were to be attended concurrently. Given the extreme level of distress and disorganization often displayed by individuals with comorbid PTSD and substance use disorders (Drapkin et al., 2011), it could be argued that these individuals are in need of highly efficient, targeted coping skills interventions that will allow them to quickly find some relief and reduce alcohol consumption before considering lengthier treatment protocols.

Coping skills with potential utility for those with comorbid PTSD/AD

The majority of substance abuse CBT treatment packages focus on the development of adaptive coping skills to prevent relapse in response to various types of triggers. In fact, brief 1–3 session coping skills training interventions have been investigated and

found to be associated with decreased substance use among individuals with substance use disorders and no significant psychiatric comorbidities (Conrod, Castellanos-Ryan, & Strang, 2010; Monti, Rohsenow, Michalec, Martin, & Abrams, 1997; Rohsenow, Monti, Martin, Michalec, & Abrams, 2000). Further, studies that have evaluated alcohol use disorder patients' ability to use coping skills have found that those who evidence improvements in coping skills have better alcohol use outcomes (Morgenstern & Longabaugh, 2000). Standard CBT treatment packages for AD, such as relapse prevention (Marlatt & Donovan, 2005; Marlatt & George, 1984), as well as those for individuals with comorbid PTSD/AD, such as Seeking Safety (Najavits, 2004; Najavits et al., 1998), offer a range of coping skill strategies to assist individuals unsuccessfully avoiding drinking. In light of the poor treatment retention often associated with comorbid PTSD/AD and this group's over-reliance on avoidant coping, clarifying the utility of teaching specific adaptive coping skills that significantly impact outcomes early in treatment is critical.

Two types of coping skills that are geared toward improving distress tolerance and emotion regulation include 1) cognitive restructuring, which is designed to facilitate flexible, balanced appraisal of situations, and 2) experiential acceptance, which is designed to facilitate acceptance of uncomfortable internal states and experiences without engaging in avoidant behaviors (i.e., drinking). Consistent with social learning theory (Bandura, 1969), a person's appraisals of current situations may be influenced by their past experiences in ways that they are not consciously aware, which can lead to inflexible cognitive schemas and sub-optimal functioning. Cognitive restructuring skills, which are commonly embedded in relapse prevention treatment packages (Larimer, Palmer, & Marlatt, 1999), can help bring such biased appraisal patterns into awareness, provide strategies for challenging them, and facilitate the generation of more realistic and more balanced thoughts and beliefs, thereby reducing emotional distress (Butler, Chapman, Forman, & Beck, 2006). In the context of substance use and PTSD, if an individual strongly believes that the only way to cope effectively with increased PTSD symptoms is to consume alcohol, they are at risk for turning frequently to alcohol to ameliorate those symptoms. Cognitive restructuring techniques would, for example, guide the person to question whether this belief is always true, whether they are perhaps confusing feelings and facts, and to generate a more realistic and balanced alternative thought about their ability to cope with symptoms without using alcohol.

An experiential acceptance approach to coping with discomfort or urges to use alcohol also encourages greater awareness of one's thoughts and feelings, but rather than challenging them (as in cognitive restructuring), the emphasis is on experiencing thoughts and feelings as passing events without judging, clinging to, or trying to change them. It is postulated that the efforts to change or suppress one's thoughts and feelings lead to increased suffering (Bowen et al., 2009; Hayes et al., 1996; Orsillo & Batten, 2005; Witkiewitz, Bowen, Douglas, & Hsu, 2013; see also Linehan, 1993) as these efforts can actually increase thoughts about the painful stimuli (Wegner, Schneider, Carter, & White, 1987; for review, see Abramowitz, Tolin, & Street, 2001). Strategies that guide people to observe their thoughts and feelings without attachment or aversion include non-judgmentally observing how the feelings come and go from different body areas through urge surfing (another component of relapse prevention; Marlatt & Donovan, 2005; Marlatt & George, 1984), radical acceptance, and mindful breathing. In sum, an experiential acceptance approach to coping posits that it is possible to tolerate distressing thoughts and feelings without avoidance and with greater acceptance, which could result in reduced reliance on drinking and alleviated suffering.

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