

Initial Evaluation of an Integrated Treatment for Comorbid PTSD and Smoking Using a Nonconcurrent, Multiple-Baseline Design

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The present study examined an integrated treatment for comorbid posttraumatic stress disorder (PTSD) and smoking entitled “Smoke-Free to Overcome PTSD: An Integrated Treatment” (STOP IT program). A nonconcurrent multiple-baseline design was used with six community-recruited adult smokers with PTSD to investigate both patient acceptance of the treatment and its initial efficacy on both PTSD and smoking. Potential order effects of exposure-based and affect management components were also examined. A gold-standard assessment strategy that included the Clinician Administered PTSD Scale (Blake et al., 1995) and biochemical verification of self-reported smoking status was employed to measure primary targets of treatment. Results suggested that the STOP IT program was well tolerated. There were clinically significant improvements in PTSD outcomes, but only temporary reductions in smoking. Participants’ relatively low posttreatment smoking levels increased by the

follow-up assessment, although not to baseline levels. Treatment component order did not appear to affect treatment outcomes, but those who were assigned to the exposure-focused writing prior to affect management training condition appeared more likely to discontinue treatment before beginning exposure. These preliminary data support the safety, acceptability, and potential efficacy of the STOP IT program. Future investigation of the STOP IT program should include testing the incremental efficacy of increasing the dose of smoking-focused intervention, as well as randomized controlled tests of the treatment that employ gold standards for treatment outcome research.

Keywords: smoking; posttraumatic stress disorder; integrated; treatment

POSTTRAUMATIC STRESS DISORDER (PTSD) AND CIGARETTE SMOKING are common, costly problems (Kessler, 2000; World Health Organization, 2009) that often co-occur (e.g., Fu et al., 2007). For example, approximately half of individuals with PTSD in the United States endorse daily smoking, which is roughly twice the smoking prevalence observed in the general population (Feldner, Babson, & Zvolensky, 2007). People with PTSD are likely to be heavy smokers, with

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research suggesting that nearly 75% smoke 20 cigarettes or more per day (Buckley, Susannah, Bedard, Dewulf, & Greif, 2004). In spite of the evidence of substantial co-occurrence, there have been few efforts to provide integrated treatments that simultaneously address PTSD and smoking. The current study represents the initial evaluation of such a treatment program.

People with PTSD are particularly vulnerable to returning to smoking during a quit attempt (Zvolensky et al., 2008). At least three interrelated mechanisms likely interfere with smoking cessation among people with PTSD, including (a) smoking to reduce negative affect; (b) elevated anxiety sensitivity (AS), or fear of the consequences of anxiety (Reiss, Patterson, Gursky, & McNally, 1986); and (c) anxious reactivity to bodily arousal, which is potentiated in states of nicotine withdrawal. First, smokers with PTSD are more likely than smokers without PTSD to smoke in response to stressful situations and negative affect (Beckham et al., 1995, 2005). More important, people with PTSD are particularly apt to smoke to reduce negative affect (Marshall et al., 2008), they report elevated expectations that smoking will reduce negative affect (Calhoun et al., 2011), and smoking appears to temporarily relieve distress among smokers with PTSD (Beckham et al., 2007).

Second, individuals with PTSD are characterized by elevated AS (Taylor, Koch, & McNally, 1992), which has been linked to problems with smoking cessation (Zvolensky, Bonn-Miller, Bernstein, & Marshall, 2006). Finally, individuals with PTSD react more anxiously to increases in bodily arousal (Feldner, Vujanovic, Gibson, & Zvolensky, 2008), which also has been linked to problems sustaining a smoking quit attempt (Zvolensky, Feldner, Eifert, & Brown, 2001).

Research on PTSD and smoking has begun to suggest a cycle wherein factors related to PTSD interfere with smoking quit attempts and nicotine withdrawal potentiates PTSD symptoms (Figure 1). Negative affect and anxiety are elicited by PTSD symptoms and nicotine withdrawal. Individuals with PTSD, who are on average high in AS (Taylor et al., 1992) and react fearfully to bodily arousal (Feldner et al., 2008), are apt to experience particularly elevated anxiety and nicotine withdrawal during a smoking quit attempt (Johnson, Stewart, Rosenfield, Steeves, & Zvolensky, 2012). The relatively high motivation to smoke in order to reduce negative affect observed among people with PTSD (Marshall et al., 2008) is likely to potentiate smoking during a quit attempt in order to reduce negative affect and anxiety related to PTSD and nicotine withdrawal (Calhoun, Dennis, & Beckham,

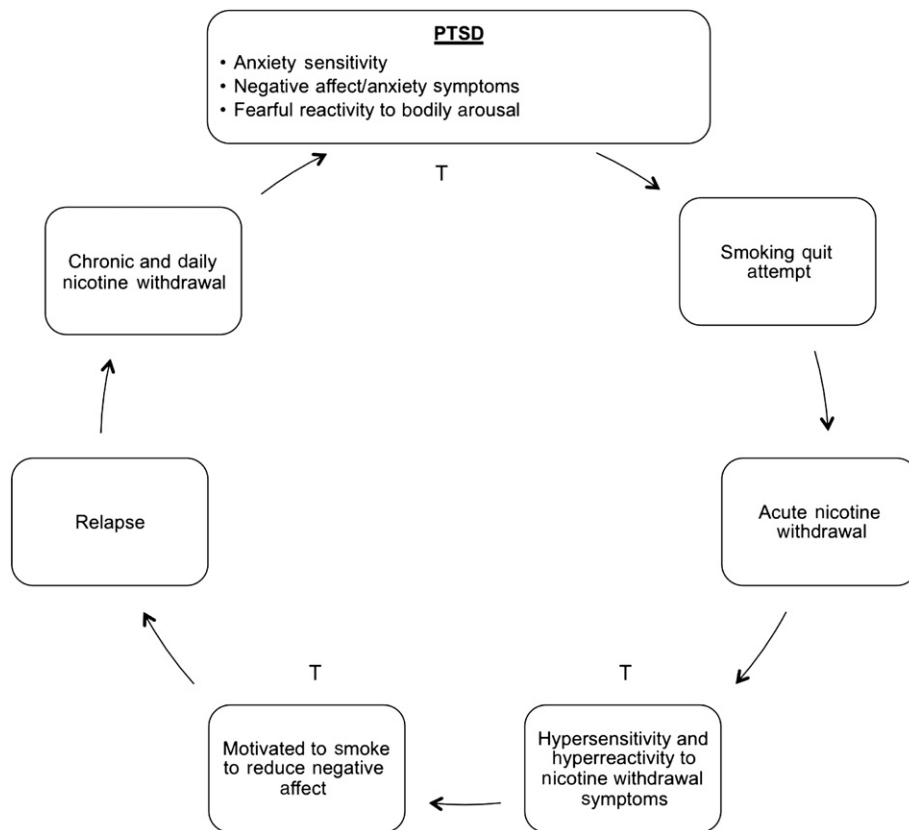


FIGURE 1 Graphic representation of PTSD-related points of intervention (indicated by a "T") of the STOP IT program.

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