



Cognitive Processing Therapy for veterans with comorbid PTSD and alcohol use disorders



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HIGHLIGHTS

- We conducted chart reviews of 536 veterans diagnosed with PTSD.
- All veterans received at least 1 session of Cognitive Processing Therapy.
- 49% of veterans exhibited a current or past AUD diagnosis.
- No significant differences on CPT completion or dropout based on AUD diagnosis.
- Significant reductions in PTSD and depression following treatment for all groups.

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ABSTRACT

Posttraumatic stress disorder (PTSD) and alcohol-use disorders (AUD) frequently present comorbidly in veteran populations. Traditionally those with alcohol dependence have been excluded from PTSD treatment outcome studies, thus we do not know how those with alcohol dependence may tolerate or respond to PTSD-specific interventions; no studies to date have examined the extent to which cognitive PTSD interventions are tolerated or effective for those with comorbid PTSD/AUD. The present study examines the extent to which CPT is tolerated by and effective in treating PTSD symptoms for veterans with PTSD and AUD, as compared to veterans with PTSD only in an outpatient treatment setting. Data were obtained through chart review of 536 veterans diagnosed with PTSD who had received at least 1 session of CPT at a Midwestern US Veterans Affairs hospital. Nearly half ($n = 264, 49.3\%$) of the veterans in the study exhibited a current or past AUD diagnosis. Participants were grouped into the following diagnostic groups: current AUD (past 12 months), past AUD (prior to 12 months), and no AUD. Participants completed an average of 9 sessions of CPT with no significant difference between AUD diagnostic groups on the number of CPT sessions completed. Individuals with past AUD had higher initial symptoms of self-reported PTSD symptoms than those with no AUD. All groups reported significant reductions in PTSD symptoms and depression over time. Overall, the results suggest that CPT appears well tolerated among veterans with comorbid AUD and is associated with significant reductions in symptoms of PTSD and depression in an outpatient treatment setting.

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1. Introduction

Large scale epidemiological research suggests that substance use disorders (SUDs) are prevalent among individuals diagnosed with posttraumatic stress disorder (PTSD) in the general population

(Jacobsen, Southwick, & Kosten, 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Mills, Teesson, Ross, & Peters, 2006), with an estimated 42% comorbidity prevalence between PTSD diagnoses and alcohol use disorders (AUDs) obtained from data from the National Epidemiologic Survey on Alcohol and Related Conditions (Pietrzak, Goldstein, Southwick, & Grant, 2011). However, among the veteran population, the rates of co-occurrence are higher. Both PTSD and AUDs are relatively common among veterans and frequently appear comorbidly (Hoge, Auchterlonie, & Milliken, 2006; Hoge et al., 2004; Milliken, Auchterlonie, & Hoge, 2007; Richardson, Frueh, &

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Acierno, 2010). In a recent study, 63% of recent veterans who met the criteria for AUDs or drug use disorders also met the criteria for PTSD, while the PTSD prevalence among those who met the criteria for both AUDs and drug use disorders (e.g., alcohol dependence and cocaine abuse) was 76% (Seal et al., 2011). The rates of comorbidity are similar among Vietnam veterans, with 73% diagnosed with PTSD among those meeting the criteria for an AUD (Kulka et al., 1990). Individuals with comorbid PTSD and SUDs are more difficult to treat, with more health and physical problems, higher mental health symptoms, higher alcohol use and consequences, drop out of treatment more often, and cost substantially more (e.g., greater degree of inpatient care) than those in treatment for SUDs without comorbid PTSD (Brown, Stout, & Mueller, 1999; Kessler, 2000; Ouimette, Brown, & Najavits, 1998; Ouimette, Goodwin, & Brown, 2006).

Considering the alarming rates of comorbidity and the high individual and societal costs of co-occurring PTSD and AUDs there have been surprisingly few studies evaluating how trauma-focused treatment may benefit those presenting for PTSD but also suffering with comorbid AUDs (Back, 2010; Conrad & Stewart, 2005). Additionally, very few studies focus on the veteran population and have evaluated whether trauma-focused treatment can benefit veterans with comorbid AUDs.

Trauma-focused intervention research studies typically exclude individuals with comorbid alcohol or drug dependence from research protocols (Riggs, Rukstalis, Volpicelli, Kalmanson, & Foa, 2003). This exclusion stems predominantly from concerns that discussing trauma-related content could lead to relapse or increased consumption rates. While traditional treatment approaches have focused on targeting one disorder prior to receiving services for the other, theory and research suggest that leaving one disorder untreated can exacerbate symptoms of the other (Najavits, 2005; Stewart, Pihl, Conrad, & Dongier, 1998). For example, among veterans, unremitted PTSD has been found to predict rates of relapse two years following substance use treatment (Ouimette, Moos, & Finney, 2000). Additionally, trauma-focused treatments are believed by some clinicians to exacerbate PTSD symptom severity (van Minnen, Harned, Zoellner, & Mills, 2012) and alcohol cravings do appear to increase in response to fluctuations in PTSD symptom severity (Simpson, Stappenbeck, Varra, Moore, & Kaysen, 2012). In an event level study conducted with treatment-seeking individuals with AUDs and PTSD, on days where PTSD symptoms were higher than average for that individual, they reported higher alcohol cravings on that day and the next (Simpson et al., 2012). Interestingly, reported reductions in PTSD symptoms during outpatient pharmacologic PTSD treatment have been associated with greater improvement in alcohol dependence symptoms compared to the opposite effect (i.e., reported greater improvements in alcohol dependence symptoms did not impact alleviation of PTSD symptoms) (Back, Brady, Sonne, & Verduin, 2006). Thus, targeting PTSD disorders specifically in treatment may help to alleviate alcohol dependence symptoms and PTSD-focused programs that wait to start PTSD treatment for those patients who are substance dependent may be missing an important clinical opportunity.

1.1. Integrated treatment for PTSD and SUDs

Research on treatment of comorbid PTSD and SUDs has predominantly focused on testing interventions that target PTSD and SUDs concurrently in treatment or interventions that specifically target trauma symptoms among patients with comorbid PTSD and SUDs. Recent reviews (Torchalla, Nosen, Rostam, & Allen, 2012; van Dam, Vedel, Ehring, & Emmelkamp, 2012) highlight the promise of integrated treatments targeting PTSD and SUDs. In a controlled study evaluating a concurrent PTSD and SUD treatment, Mills et al. (2012) found that individuals with PTSD and SUDs who received substance use treatment as usual with an added exposure component reduced their PTSD symptoms at nine-month follow-up to a significantly greater degree than those receiving only treatment as usual. Promising effects of combined treatments have been found among individuals who report alcohol

misuse (e.g., Back, Dansky, Carroll, Foa, & Brady, 2001; Back et al., 2006, 2012; Hien, Campbell, Ruglass, Hu, & Killeen, 2010; McGovern et al., 2009; Zlotnick, Najavits, Rohsenow, & Johnson, 2003). However, the majority of the integrated treatment research has consisted of uncontrolled studies, pilot studies, and case studies. The studies are limited by small sample sizes, high attrition, absence of control groups, or lack of standardization across protocols. Moreover, some recent studies have failed to find differences in outcomes between combined treatments and more standard alcohol treatments or health education controls (Cohen & Hien, 2006; Hien et al., 2009; Morrissey et al., 2005). However, these studies had their own limitations such as the use of substance use rather than alcohol use treatments. The studies focused on women in community settings and the results may not generalize to male veterans. Lastly, these studies focused on group treatment which makes it difficult to determine whether the use of a group intervention format may have influenced the findings and whether individual treatment would have demonstrated more differences between combined treatments and control conditions. In addition, combined treatments are often lengthy (upwards of 24 sessions) and complex, which can make implementation more difficult (Baschnagel, Coffey, & Rash, 2006). Thus, while promising, more research is needed to make further conclusions regarding the efficacy of integrated treatment particularly for those suffering from comorbid AUDs.

1.2. Trauma-focused interventions for comorbid PTSD and SUDs

Interventions focused on trauma content that include individuals with SUDs are also promising, yet there are fewer studies focused on these types of interventions and the majority are uncontrolled studies or case studies with small sample sizes (Torchalla et al., 2012; van Dam et al., 2012). This represents an important area for research, as studies documenting reductions in PTSD among individuals with comorbid PTSD and SUDs may encourage inclusion of comorbid individuals in research studies and in clinical settings. Thus, it is important for the field to move toward testing treatments established as efficacious for PTSD (e.g., exposure based treatments such as prolonged exposure, cognitive-based treatments such as Cognitive Processing Therapy) with comorbid individuals.

Preliminary research suggests that focusing on PTSD and trauma-related content may improve both PTSD and AUD outcomes and is able to be tolerated (e.g., Brady, Dansky, Back, Foa, & Carroll, 2001; Coffey, Stasiewicz, Hughes, & Brimo, 2006; Tuerk, Brady, & Grubaugh, 2009). For example, Coffey et al. (2006) found that individuals with PTSD and AUDs who received six sessions of imaginal exposure (i.e., repeated revisiting of the trauma memory) on an outpatient basis reported lower alcohol cravings and emotional distress in response to trauma-related cues than individuals who received relaxation training. Although attrition rates were high (17 out of 43 participants completed; 60% drop out) there were no differences in drop-out rates between the exposure and relaxation conditions lending further support to the notion that trauma content can be tolerated by those with comorbid PTSD and AUDs. While drop-out has been a concern in trauma-focused studies, it should be noted that the majority of treatment drop-outs occurred before the initiation of exposure techniques suggesting that it is not trauma content per se that contributes to study attrition (Brady et al., 2001). Taken together, research suggests that trauma-focused treatments do not necessarily lead to an exacerbation of either PTSD or substance use and that these treatments show initial promise for comorbid populations. Studies have yet to examine the extent to which primarily cognitive-based interventions for PTSD can be tolerated by those with comorbid AUDs.

The veteran population is particularly at-risk for PTSD and AUDs. Despite this there are surprisingly few studies evaluating treatment for veterans with PTSD and AUD comorbidity. Those that do exist (e.g., Cook, Walsler, Kane, Ruzek, & Woody, 2006; Donovan, Padin-Rivera, & Kowaliv, 2001; Norman, Wilkins, Tapert, Lang, & Najavits,

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