



Invited essay

Pre-treatment predictors of dropout from prolonged exposure therapy in patients with chronic posttraumatic stress disorder and comorbid substance use disorders[☆]



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ABSTRACT

Posttraumatic stress disorder (PTSD) and substance use disorders (SUDs) are commonly co-occurring disorders associated with more adverse consequences than PTSD alone. Prolonged exposure therapy (PE) is one of the most efficacious treatments for PTSD. However, among individuals with PTSD-SUD, 35–62% of individuals drop out of trauma-focused exposure treatments. Thus, it is important to identify predictors of PTSD treatment dropout among substance abusers with PTSD in order to gain information about adapting treatment strategies to enhance retention and outcomes. The current study explored pre-treatment predictors of early termination from PE treatment in a sample of 85 individuals receiving concurrent treatment for PTSD and a SUD in a residential treatment facility as part of a randomized controlled trial. The results indicated that less education and more anxiety sensitivity uniquely predicted PE treatment dropout. Demographic variables, PTSD severity, SUD severity, mental health comorbidities, and emotion regulation difficulties did not predict treatment dropout. These results suggest that adding pre-treatment interventions that address anxiety sensitivity, and promote social adjustment and cognitive flexibility, could possibly improve PE retention rates in clients with high anxiety or low education.

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1. Introduction

Posttraumatic stress disorder (PTSD) and substance use disorders (SUDs) are commonly co-occurring disorders. Among individuals seeking treatment for SUDs, approximately 36–50% will also have a lifetime PTSD diagnosis (Brady, Back, & Coffey, 2004). This is over five times greater than the U.S. lifetime prevalence rate for PTSD (Kessler et al., 2005). Co-occurring PTSD in individuals diagnosed with a SUD is associated with a host of adverse outcomes, including more intense cravings, greater length of inpatient addiction treatment, quicker relapse, and higher suicide rates (Berenz & Coffey, 2012; Brown, Stout, & Mueller, 1999; McCauley,

Kileen, Gros, Brady, & Back, 2012). Thus, treating PTSD symptoms may play an important role in breaking the cycle of continued substance use.

Prolonged exposure (PE) therapy is one of the most effective treatments for PTSD (Ballenger et al., 2000; Powers Halpern, Ferenschak, Gillihan, & Foa, 2010). Clinical trials have demonstrated that PE effectively reduced PTSD, depression, and SUD symptoms amongst those with comorbid PTSD and SUDs (hereafter PTSD-SUD; e.g., Brady, Dansky, Back, Foa, & Carroll, 2001; Coffey et al., 2016; Foa et al., 2013; Mills et al., 2012). Although exposure-based therapies have been shown to be effective for PTSD and PTSD-SUD, dropout rates are high. A recent meta-analysis estimated that 36% of individuals with PTSD drop out of exposure-based trauma treatments (Imel, Laska, Jakupcak, & Simpson, 2013). Further evidence suggests that individuals with PTSD-SUD are particularly likely to drop out of exposure-based trauma treatment. In treatment trials, 35–62% of individuals with PTSD-SUD terminate trauma-focused exposure therapies prematurely (Brady et al., 2001; Coffey et al., 2016; Foa et al., 2013; Mills

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et al., 2012; Sannibale et al., 2013). Individuals in SUDs treatment are also more likely to terminate early if they have comorbid PTSD (McCauley et al., 2012). Thus, identifying predictors of early treatment termination among those with PTSD-SUD remains an important challenge.

1.1. Demographic and socioeconomic status predictors

The previous literature has largely focused on demographic variables and clinical severity markers (i.e., PTSD severity and psychiatric comorbidity) to identify predictors of dropout from exposure-based treatment for PTSD. Importantly, these studies have predominantly been conducted in outpatient PTSD samples without a SUD, and data concerning dropout among those with PTSD-SUD are limited. Although findings have been mixed, studies focused on PTSD without a SUD have identified several demographic predictors of dropout, including male gender (van Minnen, Arntz, & Keijsers, 2002), female gender (Eftekhari et al., 2013), African American race (Lester, Artz, Resick, & Young-Xu, 2010), younger age (Jeffreys et al., 2014; Rizvi, Vogt, & Resick, 2009), less education (Rizvi et al., 2009), lower intelligence (Rizvi et al., 2009), and unemployment (Foa et al., 1999). Between the two studies that have examined factors linked to PE dropout within outpatient PTSD-SUD samples (Zandberg, Rosenfield, Alpert, McLean, & Foa, 2016; Brady et al., 2001), one found education to be associated with treatment dropout (Brady et al., 2001). Given the limited research on predictors of treatment dropout within PTSD-SUD samples and the focus on largely outpatient samples, it will be important to examine these predictors within PTSD-SUD samples as well as expand into different treatment settings (e.g., residential, inpatient).

1.2. Clinical severity predictors of dropout from exposure-based therapies for PTSD

Research on clinical severity markers predicting dropout has also shown inconsistent results. Two studies conducted in PTSD outpatient samples have found that baseline PTSD severity was significantly greater among participants who dropped out of trauma-focused treatment for PTSD compared to the participants who did complete treatment (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Zayfert et al., 2005). Other studies within PTSD outpatient samples have failed to find this association (Eftekhari et al., 2013; Rizvi et al., 2009; Taylor, 2003; van Minnen et al., 2002). Of the limited research in PTSD-SUD samples, no significant association between baseline PTSD severity or SUD severity and PE treatment dropout has been found (Brady et al., 2001; Zandberg et al., 2016). Studies examining psychiatric comorbidity as a predictor of dropout have also yielded mixed results. In a PTSD outpatient sample, Markowitz et al. (2015) recently found that individuals who had a co-occurring major depressive disorder were nine times more likely to drop out of PE treatment for PTSD. However, other PTSD outpatient studies have found no association between depressive symptomatology or other psychiatric comorbidity and PE treatment dropout (Brady et al., 2001; Eftekhari et al., 2013; Rizvi et al., 2009; Taylor, 2003; Zandberg et al., 2016; van Minnen et al., 2002). Additionally, the studies examining PTSD-SUD samples have failed to find additional anxiety or depressive symptoms to be associated with PE treatment dropout (Brady et al., 2001; Zandberg et al., 2016). Because of the scarce research in PTSD-SUD samples, along with some evidence for a potential link between clinical severity markers and dropout from PTSD treatment, it will be important to understand if clinical severity plays a role in treatment dropout amongst those with PTSD-SUD.

1.3. Individual differences in reactions to internal experiences

Given the mixed literature on demographic and clinical severity variables as predictors of dropout, it may be more fruitful to explore characteristics that relate specifically to exposure-based treatments. In exposure-based treatment, the patient is asked to tolerate and manage aversive internal experiences such as anxiety, fear, disgust, and horror. It is possible that individual differences in reactions to such experiences play an important role in early termination from exposure-based treatments. For example, anxiety sensitivity is a trait-like cognitive vulnerability that involves the fear of anxiety-related bodily sensations and their potential physical, cognitive, and social consequences (Reiss, Peterson, Gursky, & McNally, 1986). Heightened anxiety sensitivity may increase discomfort and distress associated with exposure exercises and promote dropout from treatment. Two studies in outpatient PTSD (Taylor, 2003) and PTSD-SUD (Zandberg et al., 2016) samples failed to find significant associations between anxiety sensitivity and drop out from PE. However, in a sample presumably more severe than typical outpatient samples, Lejuez et al. (2008) have shown that greater anxiety sensitivity predicts dropout from residential SUD treatment even after controlling for demographic variables, other drug variables, legal obligation to treatment, alcohol use frequency, and depressive symptoms. This suggests that anxiety sensitivity may be a particularly important predictor of treatment dropout among more clinically severe patients.

Emotion regulation difficulties may also increase discomfort with exposure exercises and promote early treatment termination. Difficulties in adaptively regulating emotions has been conceptualized by Gratz and Roemer (2004) as reflecting several dimensions, including a lack of emotional awareness, lack of emotional clarity, difficulties controlling impulsive behaviors and engaging in goal directed behavior when distressed, non-acceptance of negative emotional experiences, and limited access to effective emotion regulation strategies. Cloitre et al. (2010) found that interpersonal and emotion regulation skills training prior to exposure-based interventions for PTSD decreased treatment dropout among females with PTSD related to childhood abuse. However, it is not clear if the training reduced dropout by promoting interpersonal functioning or by addressing emotion regulation difficulties per se.

1.4. The current study

The aim of the current study was to examine pre-treatment predictors of dropout from PE in a sample of individuals receiving concurrent residential SUD and PTSD treatment in a randomized control trial. To our knowledge, only two studies have compared treatment completers and noncompleters within a PTSD-SUD sample receiving concurrent SUD and exposure-based PTSD treatment (Brady et al., 2001; Zandberg et al., 2016). However, these studies were conducted within outpatient samples of individuals reporting mild to moderately severe PTSD (Brady et al., 2001; Zandberg et al., 2016). Additionally, Zandberg et al. (2016) sample consisted of alcohol dependent individuals without additional current substance dependence beyond nicotine and cannabis. The current study examined pre-treatment predictors within a more clinically severe PTSD-SUD sample receiving more intensive treatment than in prior studies. Given the mixed literature on demographic and clinical severity markers as predictors of treatment, we did not make specific predictions about these variables. We predicted, however, that higher levels of anxiety sensitivity and emotion regulation difficulties would be associated with dropout from PE because PE requires patients to tolerate aversive internal experiences.

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