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Self-help group participation among substance use disorder patients with posttraumatic stress disorder

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Abstract

Debate has ensued about whether substance use disorder (SUD) patients with comorbid posttraumatic stress disorder (PTSD) participate in and benefit from 12-step groups. One hundred fifty-nine SUD–PTSD and 1,429 SUD-only male patients were compared on participation in 12-step activities following an index episode of treatment. Twelve-step participation was similar for SUD patients with and without PTSD. PTSD patients with worldviews (e.g., holding disease model beliefs) that more closely matched 12-step philosophy participated more in 12-step activities. Although greater participation was associated with better concurrent functioning, participation did not prospectively predict outcomes after case mix adjustment. An exception was that greater participation predicted decreased distress among PTSD patients whose identity was more consistent with 12-step philosophy. In summary, PTSD patients participate in and benefit from 12-step participation; continuing involvement may be necessary to maintain positive benefits.

Keywords: Posttraumatic stress disorder; Substance use disorder; Self-help groups; Program evaluation; Treatment course

1. Introduction

Twelve-step self-help groups are considered an essential component of continuing care for substance use disorder patients, and most professionally treated substance use disorder (SUD) patients are referred to 12-step groups (Humphreys, 1997). Yet, debate has ensued about whether SUD patients with comorbid posttraumatic stress disorder (PTSD) participate in and benefit from 12-step groups (Evans & Sullivan, 1995; Satel, Becker, & Dan, 1993).

Based on their clinical work, Evans and Sullivan (1995) argue that 12-step group involvement is an essential component of treatment for patients with traumatic stress and substance use problems. They identify several aspects of 12-step activities that may address core issues of trauma-related symptoms and enhance treatment outcomes. For example, the disease model approach to addiction may help decrease the shame that is often associated with PTSD, and the spiritual aspect of 12-step fellowship may enhance purpose in life for trauma survivors who feel hopeless about their future.

Other authors, however, have raised concerns about the effectiveness of 12-step self-help for SUD–PTSD patients. Based on clinical experience with male patients suffering from both alcohol dependence and PTSD, Satel concluded that many of these patients have difficulty affiliating with 12-step groups. Specific conflicts that inhibit SUD–PTSD patients from engaging in 12-step groups include contrasting views of which problem is primary (i.e., patients viewing the PTSD as primary, whereas 12-step members view substance dependence as primary) and of the need for psychotropic medications. The latter is problematic as PTSD patients are often prescribed medication for significant psychiatric symptoms, whereas 12-step group members may ''frown upon'' psychotropic medication use. In addition, the trauma and PTSD-specific symptom of loss of faith and hope for the future may impair an SUD–PTSD patient from embracing the view of a ''higher power,'' and PTSD-associated interpersonal avoidance may make the fellowship

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of 12-step groups problematic. Satel and colleagues suggest that 12-step groups are engaging and effective only for the minority of PTSD patients who identify as substance abusers, are more comfortable with social situations, and have less severe psychological symptoms. Thus, patients who exhibit these characteristics should have better outcomes following 12-step participation.

Two empirical studies (Ouimette, Ahrens, Moos, & Finney, 1998; Ouimette, Moos, & Finney, 2000) have examined the association of self-help group participation and SUD–PTSD patients' treatment outcomes. Among SUD–PTSD patients receiving SUD treatment, involvement in 12-step activities during treatment (e.g., reading 12-step literature, associating with peers who are involved in self-help, attending meetings) was associated with more adaptive coping and decreased psychological symptoms at discharge. In a second study of these same patients, posttreatment self-help group attendance during the two years after the index episode was related to stable remission from substance abuse (Ouimette et al., 2000). Based on these findings, self-help group participation was recommended as a potential adjunct to treatment for SUD–PTSD patients (Ouimette, Brown, & Najavits, 1998).

SUD–PTSD patients have multiple psychiatric and medical comorbidities and poorer treatment outcomes, and use more costly care options than SUD patients without PTSD (Brown, Recupero, & Stout, 1995; Brown, Stout, & Mueller, 1999). The complexity of these patients creates both clinical and cost challenges for health care systems, as frequent contact with care providers is needed. Hence it is critical to evaluate whether self-help groups are an effective adjunct to formal therapy for SUD–PTSD patients. In this study, we extend previous work by examining the concurrent and predictive (prospective) associations between engagement and specific indices of treatment outcomes, including substance use, psychological, employment, and social outcomes. We examine four interrelated questions regarding self-help group participation among SUD–PTSD patients:

1. Among SUD patients, is PTSD associated with less 12-step group participation during the 2 years following an index episode of inpatient treatment?

2. Among PTSD patients, what predicts engagement in 12-step groups during the 2 years after the index episode of treatment? As proposed by Satel et al. (1993), we expect that PTSD patients with views/goals consistent with 12-step philosophy (e.g., having more religious beliefs and behaviors), who are not using psychotropic medication, who are more socially involved, and who have fewer psychological symptoms will participate more in 12-step groups.

3. Among PTSD patients, does greater self-help group participation predict a greater likelihood of abstinence and employment, a lower likelihood of psychological distress, and more social support from friends during these 2 years?

4. Among PTSD patients, do specific patients gain more benefit from 12-step participation on 2-year outcomes? Specifically, as proposed by Satel et al. (1993), we expect that PTSD patients who identify as alcoholics/addicts, engage more in social activities, and have fewer psychological symptoms to evidence greater associations between participation and enhanced 2-year outcomes than PTSD patients without these characteristics.

2. Methods

2.1. Participants

Participants were selected from male VA patients in a multisite program evaluation of cognitive-behavioral, 12-step, and eclectic inpatient treatment for substance abuse (Moos, Finney, Ouimette, & Suchinsky, 1999; Ouimette, Finney, & Moos, 1997). Patients were asked to participate in the evaluation after they had completed medical detoxification and were admitted to the programs. Due to their small numbers, women were excluded from the evaluation. Procedures followed in this evaluation were in accord with the institutional review boards at the coordinating center of the study and at the individual sites.

The initial intake sample included 159 SUD–PTSD patients, of whom 146 (91.8%) completed a Discharge Information Form (DIF) at the end of the index treatment episode, 140 (88.1%) completed a 1-year Follow-up Information Form (FIF), and 135 (84.9%) completed a 2-year Follow-up Information Form. Identification of SUD–PTSD patients has been described in detail previously (Ouimette, Ahrens, Moos, & Finney, 1997, 1998; Ouimette, Finney, & Moos, 1999; Ouimette et al., 2000), but to summarize briefly: Patients were classified into diagnostic categories using intake and discharge chart diagnoses given by doctoral-level program staff. These diagnoses were based on the Diagnostic and Statistical Manual of Mental Disorders-III-Revised (American Psychiatric Association, 1987). Only patients with psychiatric diagnoses on which there was 100% agreement at both assessments were retained as participants. Exclusion criteria were the presence of organic disorders, developmental disorders, impulse control disorders, and eating/sleep disorders.

The comparison group consisted of 1,429 patients with only substance use disorders. PTSD patients were older ($M = 44.96$, $SD = 4.57$) than SUD-only patients ($M = 42.76$, $SD = 10.22$). PTSD patients had slightly higher levels of education ($M = 13.07$, $SD = 1.64$) than did SUD-only patients ($M = 12.60$, $SD = 1.78$). Significantly fewer PTSD patients were from African American and other minority groups (42.1%) than were SUD-only patients (57.1%). No significant differences emerged between the groups on the proportion of patients married or living with a partner (PTSD patients, 38.6%; SUD-only patients, 32.1%) or on the completion rates for the follow-ups.