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BEHAVIORS**

Addictive Behaviors 28 (2003) 1717–1730

Demographic and social adjustment characteristics of patients with comorbid posttraumatic stress disorder and alcohol dependence: Potential pitfalls to PTSD treatment

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Abstract

The present study examined the demographic and social adjustment characteristics of a sample seeking treatment for comorbid posttraumatic stress disorder (PTSD) and alcohol dependence (AD). Using descriptive statistics, we compared the characteristics of this group to those of a sample seeking treatment for PTSD alone and to another sample seeking treatment for AD alone. Results indicated that compared to the PTSD alone and AD alone samples, a greater percentage of the comorbid sample was unemployed, with low income and living without the support of a spouse or intimate partner. Further, participants in the comorbid sample were less likely than those in the PTSD alone sample to have received more than a high school education, though the comorbid and AD samples were comparable on education level. These results are discussed with attention to how poor social adjustment may place comorbid AD–PTSD patients at greater risk for premature termination of therapy, particularly when that treatment is focused on alleviating PTSD symptoms. Suggestions are made to enhance retention of these difficult patients in treatment programs.

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Keywords: Alcohol dependence; PTSD; Social adjustment

1. Introduction

Approximately 70% of adults in the United States have experienced at least one severe trauma in their lives (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) and posttraumatic

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stress disorder (PTSD) occurs in approximately 8% of the U.S. population (Breslau, Davis, Andreski, & Peterson, 1991; Davidson & Fairbank, 1993; Kessler et al., 1995). Over the last 15 years, cognitive-behavioral treatment programs based on exposure to trauma memories and reminders have been shown highly effective in treating PTSD (cf., Foa & Meadows, 1997; Foa & Rothbaum, 1998). However, PTSD patients who also suffer from alcohol dependence (AD), a common comorbidity among people with PTSD (e.g., Chilcoat & Menard, 2003; Langeland & Hartgers, 1998; Najavits, Weiss, & Shaw, 1997; Ouimette, Brown, and Najavits, 1998), are typically excluded from treatment trials because it is thought that the stress of exposure therapy will increase alcohol use and that these patients are at high risk for premature termination from therapy. In the present study, we examine the demographic and social adjustment characteristics of a group of patients seeking treatment for comorbid PTSD and AD to determine whether they may be at increased risk for premature termination from exposure therapy for PTSD.

Over the past 15 years, many studies have examined the efficacy of various cognitive-behavioral treatment (CBT) programs for PTSD, rendering CBT the most empirically validated approach among the psychosocial treatments for PTSD (cf., Foa & Meadows, 1997; Foa & Rothbaum, 1998). Among the CBT approaches, the effectiveness of exposure therapy (those in which clients are encouraged to confront memories of the trauma) has been demonstrated more than any other treatment (Foa & Rothbaum, 1998; Rothbaum, Olasov, Meadows, Resick, & Foy, 2000). Exposure therapy was originally used with combat veterans (Cooper & Clum, 1989; Keane, Fairbank, Caddell, & Zimering, 1989) and was then found effective for female victims of physical and sexual assault (Foa et al., 1999; Foa, Rothbaum, Riggs, & Murdock, 1991). Subsequently, variations of exposure therapy have been effective for both men and women and for treating PTSD associated with a wide variety of traumas (e.g., Devilly & Spence, 1999; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Richards, Lovell, & Marks, 1994; Tarrrier et al., 1999). The use of exposure therapy with PTSD patients who also have a substance use disorder (SUD) has not been well researched. Two small studies used exposure therapy for PTSD combined with coping skills training (CST) to treat patients with PTSD and comorbid cocaine dependence (Brady, Dansky, Back, Foa, & Carroll, 2001) or mixed SUDs (Triffleman, Carroll, & Kellogg, 1999) with some success. There are no studies on the use of exposure therapy for comorbid AD and PTSD (AD-PTSD).

Several recent reviews have corroborated long-standing clinical impressions that AD is linked to trauma exposure and PTSD (e.g., Brown & Wolfe, 1994; Chilcoat & Menard, 2003; Langeland & Hartgers, 1998; Najavits et al., 1997; Stewart, 1996). Estimates of alcohol abuse among patients with trauma exposure or PTSD range between 16% and 68% (Boudewyns, Albrecht, Talbert, & Hyer, 1991; Boudewyns, Hyer, Woods, Harrison, & McCranie, 1990; Davidson, Kudler, Saunders, & Smith, 1990). These rates are substantially higher than the 1-year prevalence estimates of alcohol abuse or dependence of 7–9% found in the general population (Grant et al., 1991; Grant, Harford, Dawson, & Chou, 1994; Helzer, Burnam, & McEvoy, 1991). Compared to PTSD only patients, AD-PTSD patients have more severe PTSD symptoms, more dissociative symptoms, and more borderline personality characteristics (Behar, 1987; Ouimette, Wolfe, & Chrestman, 1996; Saladin, Brady, Dansky, & Kilpatrick, 1995).

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