



Psychological interventions for post-traumatic stress disorder and comorbid substance use disorder: A systematic review and meta-analysis



Neil P. Roberts ^{a,b,*}, Pamela A. Roberts ^{b,c}, Neil Jones ^c, Jonathan I. Bisson ^a

^a Institute of Psychological Medicine and Clinical Neurosciences, Cardiff University School of Medicine, Cardiff, UK

^b Psychology and Counselling Directorate, Cardiff and Vale University Health Board, Cardiff, UK

^c Community Addiction Service, Cardiff and Vale University Health Board, Cardiff, UK

HIGHLIGHTS

- Comorbid PTSD and SUD are difficult to treat.
- Drop-out from treatment is high.
- There is evidence of benefit from approaches that include trauma-focused intervention.
- There is little evidence for non-trauma-focused approaches at present.
- The quality of current evidence is low.

ARTICLE INFO

Article history:

Received 14 October 2014
Received in revised form 20 January 2015
Accepted 24 February 2015
Available online 3 March 2015

Keywords:

Posttraumatic stress disorder
Substance use disorder
Comorbidity
Psychological intervention
Meta-analysis

ABSTRACT

Co-morbid post-traumatic stress disorder (PTSD) and substance use disorder (SUD) are common, difficult to treat, and associated with poor prognosis. This review aimed to determine the efficacy of individual and group psychological interventions aimed at treating comorbid PTSD and SUD, based on evidence from randomised controlled trials. Our pre-specified primary outcomes were PTSD severity, drug/alcohol use, and treatment completion. We undertook a comprehensive search strategy. Included studies were rated for methodological quality. Available evidence was judged through GRADE. Fourteen studies were included. We found that individual trauma-focused cognitive-behavioural intervention, delivered alongside SUD intervention, was more effective than treatment as usual (TAU)/minimal intervention for PTSD severity post-treatment, and at subsequent follow-up. There was no evidence of an effect for level of drug/alcohol use post-treatment but there was an effect at 5–7 months. Fewer participants completed trauma-focused intervention than TAU. We found little evidence to support the use of individual or group-based non-trauma-focused interventions. All findings were judged as being of low/very low quality. We concluded that there is evidence that individual trauma-focused psychological intervention delivered alongside SUD intervention can reduce PTSD severity, and drug/alcohol use. There is very little evidence to support use of non-trauma-focused individual or group-based interventions.

© 2015 Elsevier Ltd. All rights reserved.

Contents

1. Introduction	26
2. Methods	28
2.1. Outcomes	28
3. Data extraction	28
3.1. Assessment of methodological quality	28
3.2. Main and subgroup analyses	28
3.3. Statistical analyses and quality of evidence	28

* Corresponding author at: Institute of Psychological Medicine and Clinical Neurosciences, Cardiff University School of Medicine, Cardiff, UK.
E-mail address: RobertsNP1@Cardiff.ac.uk (N.P. Roberts).

4. Results	29
4.1. Interventions	31
4.1.1. Individual trauma-focused approaches	31
4.1.2. Individual non-trauma-focused approaches for PTSD and SUD	31
4.1.3. Group-based non-trauma-focused approaches for PTSD and SUD	31
4.1.4. Individual non-trauma-focused approaches for PTSD only	31
4.1.5. Quality of methodology	31
4.2. Assessed outcomes and evidence synthesis	31
4.2.1. Individual trauma-focused intervention	31
4.2.2. Individual non-trauma-focused intervention	33
4.2.3. Group-based non-trauma-focused intervention	33
4.2.4. Individual non-trauma-focused intervention for PTSD only	33
5. Conclusion	33
Role of funding sources	35
Author contributions	35
Conflict of interest	35
Acknowledgements	35
Appendix A.	35
Appendix B. Study characteristics related to the risk of bias	36
References	37

1. Introduction

Post-traumatic stress disorder (PTSD) and Substance Use Disorder (SUD) are common and well recognised psychiatric disorders with established psychological and pharmacological treatment approaches. For PTSD trauma-focused cognitive behavioural therapies and Eye Movement Desensitisation (EMDR) are currently the most efficacious psychological treatments (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Bradley, Greene, Russ, Dutra, & Westen, 2005). For SUD a number of interventions based on the principles of CBT and behaviour therapy have been found to be effective. These include coping skills training, relapse prevention, contingency management and behavioural couples' therapy (Knapp, Soares, Farrell, & Silva de Lima, 2007; Mayet, Farrell, Ferri, Amato, & Davoli, 2004; Powers, Vedel, & Emmelkamp, 2008).

Comorbidity between PTSD and SUD is common: amongst individuals with SUD, the prevalence of lifetime PTSD ranges from 26% to 52%, with prevalence of current PTSD ranging from 15% to 42% (Dragan & Lis-Turlejska, 2007; Driessen et al., 2008; Mills, Teeson, Ross, & Peters, 2006; Reynolds, Hinchliffe, Asamoah, & Kouimtsidis, 2011; Reynolds et al., 2005; Schäfer et al., 2010). In PTSD diagnosed samples, the prevalence of co-morbid SUD (excluding alcohol use disorder) ranges from 19% to 35% (Breslau & Davis, 1992; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Mills et al., 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011). Alcohol use disorder (AUD) has consistently been found to be the most commonly co-occurring SUD co-morbidity, with prevalence rates ranging from 36% to 52% (Breslau & Davis, 1992; Kessler et al., 1995; Mills et al., 2006; Pietrzak et al., 2011). Prevalence rates for both alcohol and drug abuse appear to be higher for men with PTSD than women (Kessler et al., 1995). Estimates of comorbidity have been even higher in some populations, such as combat veterans (Jacobsen, Southwick, & Kosten, 2001; Keane & Wolfe, 1990; Kulka et al., 1990; McDevitt-Murphy et al., 2010).

Patients with both disorders have been found to have a more severe clinical profile than those with either disorder alone, lower general functioning, poorer well-being and worse outcomes across a variety of measures (Schäfer & Najavits, 2007). Co-morbidity with other psychiatric disorders, such as affective disorders, anxiety disorders and personality disorders is also increased. This results in additional individual, familial and societal burdens (Mills et al., 2006; Schäfer & Najavits, 2007). For these reasons, randomised controlled

trials evaluating PTSD treatment interventions routinely exclude individuals with substance misuse-related problems (Ouimette et al., 2003).

Individuals with PTSD and SUD co-morbidity are perceived as being more difficult to treat than individuals with either condition alone, for various reasons (Schäfer & Najavits, 2007). The co-morbidity is associated with poorer recruitment and retention in treatment programs, poorer treatment outcomes, poorer treatment adherence, and shorter periods of abstinence post-treatment (Brown, Read, & Kahler, 2003; Foa & Williams, 2010; Ouimette et al., 2003; Ouimette, Moos, & Finney, 2003; Reynolds et al., 2005; Schäfer & Najavits, 2007). Despite high prevalence levels, adults in treatment for SUD are frequently not assessed for PTSD or offered PTSD-based interventions (Ford, Hawke, Alessi, Ledgerwood, & Petry, 2007; Mills et al., 2006; Ouimette et al., 2003; Reynolds et al., 2005). Most diagnosis-specific guidelines for PTSD make little reference to whether specific treatment recommendations apply to SUD co-morbidity (Watkins, Hunter, Burnam, Pincus, & Nicholson, 2005) and there is no real consensus about best practice. Many clinicians still argue the SUD should be treated first (e.g., Busuttil, 2009; Zayfert & Becker, 2007), or that abstinence is necessary before diagnosis and a management plan can be made (e.g., Busuttil, 2009). The reality is that patients frequently get passed between services with little co-ordination of care (Najavits, 2006).

A number of different explanations for the relationship between SUD and PTSD have been proposed (Meyer, 1986; Schäfer & Najavits, 2007). One explanation is that problematic substance use increases the risk of being exposed to trauma and psychological vulnerability to the effects of trauma (Meyer, 1986; Schäfer & Najavits, 2007). A second explanation is that individuals with PTSD may seek symptom relief through drug or alcohol use, potentially leading to the development of SUD (Khantzian, 1985; Kline et al., 2014; Schäfer & Najavits, 2007). This has become known as the “self-medication hypothesis” (Khantzian, 1985). A third explanation is that PTSD and SUD may stem from shared but independent aetiologies (Berenz & Coffey, 2012; Kline et al., 2014; Krueger & Markon, 2006). Proposed common liabilities include, shared genetic risk (e.g., Wolf et al., 2010), common personality traits, such as impulsivity (Schauberg et al., 2015; Weiss, Tull, Viana, Anestis, & Gratz, 2012; Weiss, Tull, Anestis, & Gratz, 2013), and common environmental factors, such as trauma exposure (Kline et al., 2014).

Download English Version:

<https://daneshyari.com/en/article/903611>

Download Persian Version:

<https://daneshyari.com/article/903611>

[Daneshyari.com](https://daneshyari.com)