

Prolonged Exposure With Veterans in a Residential Substance Use Treatment Program

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Prolonged exposure therapy (PE) is effective in reducing posttraumatic stress disorder (PTSD) symptoms among individuals with comorbid substance use disorder (SUD) and PTSD. However, concerns that PE will lead to negative outcomes such as dropout and relapse remain a barrier to high-risk individuals, such as those warranting residential SUD care, receiving PE. The goal of this study was to gather information on feasibility, acceptability, and efficacy of offering PE in residential SUD treatment. Study therapists conducted PE (3 times/week, up to 15 sessions) with 9 patients admitted to a residential SUD treatment program at a Veterans Affairs (VA) hospital. Participants completed the PTSD Symptom Checklist (PCL-S) and Patient Health Questionnaire (PHQ-9) at admission, at discharge from the 4- to 6-week program, and 3-months postdischarge follow-up. Patients who were offered PE tolerated and engaged in PE as indicated by completion of the protocol, high satisfaction scores, and clinically significant decreases in PTSD and depression symptom severity. Symptom reduction at follow-up was significantly greater among patients who received PE than those who did not ($n = 21$). This preliminary data provides initial support for further investigation of the efficacy of PE in residential SUD care.

SUBSTANCE use disorders (SUDs) comorbid with posttraumatic stress disorder (PTSD) are common following trauma exposure. In the general U.S. population, the prevalence of alcohol and substance use disorders is approximately 35% and 29% (respectively) among individuals with PTSD, compared to 24% and 11% (respectively) among those without PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Co-occurring PTSD/SUD is associated with worse treatment outcomes for both disorders, greater risk of suicidality and homelessness, increased disease burden, and greater functional disability than having a single disorder (Calabrese et al., 2011;

Driessen et al., 2008; Edens, Kaspro, Tasi, & Rosenheck, 2011; Possemato, Wade, Anderson, & Ouimette, 2010).

Psychotherapies that include trauma processing have been shown to be among the most effective treatments for PTSD (Institute of Medicine, 2007). Perhaps the most well-studied trauma processing therapy is prolonged exposure (PE; Foa, Hembree, & Rothbaum, 2007). PE requires that patients expose themselves to reminders of the trauma and other avoided stimuli (in-vivo exposure), as well as the trauma memory itself (imaginal exposure). Both in-vivo and imaginal exposures work through the promotion of habituation to distressing stimuli. Over two decades of research studies demonstrate that PE is a highly effective treatment for PTSD and that treatment gains are maintained over time (see meta-analysis by Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Exposure to avoided stimuli and memories may sometimes raise distress in the short term, but also allows individuals to habituate to safe environments and learn that they are able to handle these stimuli and memories.

Keywords: prolonged exposure; substance use disorder; PTSD; comorbid; residential treatment

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Although randomized controlled trials of PE have been conducted largely in outpatient settings, PE has been implemented within some intensive PTSD residential treatment settings (e.g., Cook et al., 2013). Cook and colleagues suggest that in order to make PE and other evidence-based treatments for PTSD feasible for residential treatment settings, modifications may be necessary. For example, sessions may need to be conducted more frequently in order to complete therapy in the time a patient is in the residential program. The authors identified barriers to PE in the residential setting, including perceptions by some providers that their patients were too severe or unstable to take part in a trauma processing treatment.

Having an SUD in addition to PTSD can be a barrier to receiving PE (Becker, Zayfert, & Anderson, 2004). Historically, PTSD/SUD has been treated sequentially; SUDs have typically been treated first followed by PTSD treatment after a sustained period of abstinence. Patients with SUDs have not been offered PE or other trauma processing therapies because of beliefs that the ensuing distress would be counterindicated for patients in early SUD recovery (Becker et al., 2004). That is, exposure and trauma processing were thought to exacerbate symptoms and thus increase the risk of relapse (Pitman et al., 1991). Recent studies refute this notion and instead demonstrate that outpatients in early SUD recovery can indeed handle and benefit from exposure therapy (Foa et al., 2013; Mills et al., 2012; Roberts, Roberts, Jones, & Bisson, 2014). Guideline recommendations for treatment of comorbid PTSD and SUD recommend offering best available treatments for both disorders concurrently (VA/DoD Management of Post-Traumatic Stress Working Group, 2010). However, little is known about offering PE or any trauma processing therapy in residential SUD treatment.

Residential treatment is generally considered an appropriate level of care for severe SUD patients. In this setting, patients receive intensive treatment in a structured environment to help with the challenges of early recovery and to develop sufficient skills to safely transition to less intense levels of care (Mee-Lee, Shulman, Fishman, Gastfriend, & Griffith, 2001). It is important to examine PTSD treatment in residential SUD settings because almost 40% of individuals seeking SUD treatment receive care at a residential facility at some point (Substance Abuse and Mental Health Services Administration, 2008). Further, over 25% to 50% of individuals seeking SUD treatment meet current criteria for PTSD (Brady, Back, & Coffey, 2004; Brown, Stout, & Mueller, 1999; Jacobsen, Southwick, & Kosten, 2001).

There are reasons to believe that offering PE in residential SUD treatment may be helpful to long-term recovery. Research indicates that individuals with PTSD relapse more quickly following residential SUD treatment

compared to individuals without PTSD (Brown, Stout, & Mueller, 1996), and PTSD is linked to dropout from residential SUD treatment (Tull, Gratz, Coffey, Weiss, & McDermott, 2013). The relapse and dropout rates are posited to be associated with the intense and frequent emotional distress associated with PTSD (Ouimette, Finney, & Moos, 1999). Further evidence of the need to examine PTSD treatment among severe SUD patients comes from intriguing findings by Fontana, Rosenheck, and Desai (2012), who found that, among veterans in residential PTSD treatment, those with comorbid PTSD and SUD had better PTSD outcomes compared to those with PTSD alone. The authors attributed the differences primarily to improvement in comorbid SUD symptoms, and suggest that there may be a synergistic effect in the treatment of the two disorders. Their findings further refute the notion that the presence of an SUD impedes patients' ability to benefit from PTSD treatment. In fact, they conclude that treating both disorders simultaneously may help patients benefit from treatment for the other disorder as well.

Henslee and Coffey (2010) identified several practical barriers to implementing PTSD treatment into an SUD residential program given the confined structure and limited time on the unit. Suggestions to overcome these barriers include conducting sessions twice weekly in order to complete PE within the length of stay of a residential program, shortening sessions to 60 minutes to fit within the residential treatment schedule, loaning patients audio recorders with headphones to be able to complete assignments in privacy, and using virtual means such as internet resources (e.g., images, sounds) to conduct in-vivo exposures (Henslee & Coffey, 2010).

Berenz, Rowe, Schumacher, Stasiewicz, and Coffey (2012) described the course of treatment for four individuals offered PE in a 6-week community-based residential alcohol use disorder (AUD) treatment. Patients who received PE completed nine 60-minute sessions twice weekly, as well as in-vivo and imaginal exposure homework between sessions. Notably, none of the patients met criteria for PTSD at the end of treatment, and treatment gains were maintained at 3- and 6-months posttreatment. Furthermore, the patients did not relapse in response to undergoing exposure therapy. This small study is significant in that it demonstrates the feasibility and acceptability of incorporating PE in a community residential AUD treatment program.

It is important to also examine PE within SUD residential treatment in Veterans Affairs (VA) medical centers, as VA programs are often shorter (3 to 4 weeks) than the 6-week program described by Berenz et al. (2012), and the hospital setting creates unique challenges to completing exposure assignments. Further, PTSD/SUD comorbidity is highly prevalent among veterans.

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