This review outlines research on the relationship between trauma-related problems and substance abuse/dependence. Discussions of conceptual issues and best practices are provided for review along with a description of several “integrated” treatment programs that developed since the late 1990s to treat patients experiencing substance use disorders (SUD) and post-traumatic stress disorder (PTSD). Empirical evidence for these programs is reviewed along with preliminary recommendations for the Treatment Standards Committee of RX 2000.

**Background**

The experiences of Canadian peacekeepers in recent years has resulted in the development of policies and programs to manage psychological trauma and PTSD within the Canadian Forces. These programs have established formal standards to identify and treat psychological stress injuries, including PTSD. However, across Canada, there is variability in terms of how programs are organized and staffed. These differences extend also to the identification and treatment of substance abuse/dependence problems among patients with PTSD.

In terms of identification and treatment of SUDs, programming in the Canadian Forces began in the 1960s. Over time, these efforts were formalized within a mixed medical and administrative framework designed to enforce abstinence among serving members. Failure by patients to comply with these measures triggered progressive disciplinary processes eventually culminating in termination from the CF. At present, this structure is under review within the military. In particular, efforts are underway to separate work performance issues from a medical mandate to assess and treat patients.
experiencing these disorders. This shift in philosophy is timely given the data suggesting that the diagnosis of alcohol dependence for military personnel referred to intensive treatment programs is often questionable (see Whelan, 2001).

Whelan’s (2001) findings raised concerns about the accuracy of addiction assessments and whether other disorders were not being detected during addiction assessments (e.g., major depression, anxiety disorders, PTSD, or disorders of personality). This study also raised the prospect that traditional abstinence-based interventions could be counterproductive for some patients in terms of their psychological status and lack of progress in managing social relationships following treatment. This concern has been reported also by other addiction researchers (e.g., Brown, 2000; Ouimette, Ahrens, Moos, & Finney, 1998; Thevos, Brown, Malcolm, & Randall, 1996). A recent review of best practices in addiction treatment commissioned by the CF takes a clear stand that coercive and punitive approaches to addiction problems are likely outdated and non-productive in bringing about behavior changes among SUD patients (see Patton, Lemaire, & Pankratz, 2003).

This focus on patient suitability for addictions treatment is consistent with other studies indicating that comorbid mental health problems, personality disorders, and PTSD negatively affect substance abuse treatment outcomes (Murray, Anthenelli, & Maxwell, 2000; Thevos, Brown, Malcolm, & Randall, 1996). Findings from studies of U.S. military veterans concur with these results (e.g., Kolb, Pugh, & Gunderson, 1978; Kolb, Coben, & Heckman, 1981; Trent, 1994). In the case of patients with concurrent PTSD, concerns about the timing and intensity of interventions aimed at abstinence are echoed by prominent trauma researchers (see Wilson, 2001). A conclusion from these studies is
that if patients with mental health problems are to be treated for addiction problems, then specific treatment modalities for these particular problems need to be incorporated into addiction programs (Bourgeois, Nelson, Slack, & Ingram, 1999).

Given the apparent overlapping populations seen by mental health and addiction workers, there is a need to determine the potential benefits to patients from closer working relationships. As it stands, there are clear boundaries between these services in many civilian and military centres.

LITERATURE REVIEW

Addiction and trauma represent, at one level, the avoidance of strong emotion and arousal that can be extremely distressful to sufferers (Handelsman, Stein, Bernstein, Oppenheim, Rosenblum, & Magura, 2000). As stated succinctly by Cramer (2002):

PTSD and addiction are a marriage made in the avoidance of unbearable affect; an avoidance that is costly in the resulting traumatic reenactments experienced by patients whose attempts to escape the past keep them evermore tightly bound to it (p. 194).

Along with this restricted ability to identify and express emotion there is often a “paradoxical double problem” characterized by an over-experiencing of severe negative affect (especially hostility/anger) (Handelsman et al., 2000). In response to these problems, trauma survivors often develop dependence upon central nervous system (CNS) depressants (Jacobson, Southwick, & Kosten, 2001). The research suggests that women appear more likely than men to use alcohol and drugs to cope with stress/trauma (Back, Sonne, Killeen, Dansky, & Brady, 2003). Even so, among men with PTSD, alcohol abuse/dependence is the most common co-occurring disorder, followed by depression, other anxiety disorders, and conduct disorder (Jacobson et al., 2001).
Where there is a protracted history of trauma, the severity of addiction problems seems to be worse and successful recovery appears to be much more difficult to initiate and to maintain. In the case of a diagnosis of PTSD, the prognosis on the addiction front is often poor. In fact, undiagnosed PTSD among clientele in addiction treatment centres may account for many of the instances of treatment failure/relapse. On the PTSD front, the use of substances by patients often serves to maintain a pattern of emotional avoidance and disconnection from self and others in response to trauma cues. Patients use alcohol and drugs (and other behaviors such as gambling) to help them to maintain a sense of personal control over particular symptoms including, rage, nightmares, and dissociation. They often react in fear and ambivalence (which is reinforced frequently by their real life experiences) over the prospect of giving up alcohol or drugs and facing distressful PTSD symptoms.

**Prevalence estimates of PTSD-SUD rates**

Results of the National Comorbidity Survey (NCS) in the US show lifetime prevalence rates for alcohol dependence at approximately 10%. Estimates of PTSD in this population vary from 19% to 59% (Back et al., 2003) and 20% to 30% (Ouimette, Moos, & Brown, 2003). A more precise estimate reported by Jacobson et al. (2001) found that 43% of those in inpatient treatment for alcohol problems meet criteria for PTSD. People who were physically and/or sexually abused as children seem to be at higher risk for dual disorders (de Bernardo, Newcomb, Toth, Richey, & Mendoza, 2002). Research with PTSD patient samples show that 80% of them also experience lifetime depression, other anxiety disorders and/or substance abuse problems (Foa, Keane, & Friedman, 2000).
Among military personnel, approximately 60% to 80% of Vietnam veterans seeking help for PTSD also receive a diagnosis of alcohol abuse/dependence (Kofoed, Friedman, & Peck, 1993; Meisler, 1996; Stewart, Pihl, Conrod, & Dongier, 1998); 40% to 44% of them have drug abuse/dependence problems (Stewart et al., 1998). Ruzek (2003) estimated the incidence of drug abuse/dependence among male veterans with PTSD to be between 25% to 56%. “Harder drugs”, including cocaine and opiates, are linked consistently with more severe forms of trauma (Meisler, 1996; Najavits et al., 1998).

For veterans of the Gulf War, the problems most often reported in medical settings included PTSD, alcohol abuse and dependence, and unexplained physical symptom syndromes (Ruzek, 2003). In recent studies, the development of PTSD among soldiers has been linked also to non-combat experiences, including witnessing the suffering of others such as the people of Somalia (similar to experiences reported by Canadian Forces peacekeepers) and sexual harassment by other military personnel (Ruzek, 2003).

CONCEPTUAL EXPLANATIONS OF LINKS BETWEEN PTSD AND SUD

Trauma histories are relatively common among substance abuse patients (Langeland, van Den Brink, & Draijer, 2002). These high rates of overlap suggest a functional relationship between the two disorders. According to Stewart et al. (1998) and Volpicelli, Balaraman, Wallace, and Bux (1999), there exist a number of possible relationships. Several of these are described below.

Alcohol/drug intoxication increases the risk of trauma exposure
A common belief among clinicians is that the use of drugs and heavy drinking increases involvement in risky behaviours and places people in unsafe situations that expose them to potentially traumatizing incidents (e.g., sexual assault, motor vehicle accidents, or violent robbery). However, contrary to this popular belief, the evidence does not support the notion that alcohol or drug use places individuals at greater risk for victimization (Jacobson et al., 2001; Stewart & Conrod, 2003).

**Trauma survivors attempt to self-medicate their symptoms**

During stressful events, as described by Volpicelli et al. (1999), naturally occurring endorphins release into the bloodstream and help moderate reactions to traumatic events. Following resolution of the event, however, there is a rapid decline in endorphin levels and subsequent increase in experiences of emotional distress. Under the endorphin compensation hypothesis, people often resort to alcohol/drugs to manage this rebound dysphoria. This physiological reaction is consistent with comments by trauma survivors and patients diagnosed with PTSD that they often use alcohol, heroin, marijuana, benzodiazepines, and other depressant medications to help them to sleep, reduce irritability and hypervigilance, and control excessive startle (Inaba, 1997; Ouimette et al., 2003; Stewart & Conrod, 2003). Other drugs are linked with PTSD numbing symptoms (e.g., prescription depressant medications) and dependence on prescription analgesics is associated with efforts by patients to reduce intrusive memories (Stewart & Conrod, 2003).

There is a lack of data for the hypothesis that patients drink alcohol to manage nightmares by interfering with the rapid eye movement (REM) sleep phase. Alternatively, heavy drinking may serve to exacerbate sleep-cycle disturbances
characteristic of PTSD patients (Stewart et al., 1998). The relationship between cocaine use and PTSD is unusual in that it has been linked with a worsening of hyperarousal symptoms (Ouimette et al., 2003; Stewart et al., 1998). In their research with cocaine addicted patients, Coffey, Saladin, Drobes, Brady, Dansky, and Kilpatrick (2002) speculated an absence of links between cocaine use and avoidance symptoms but instead that cocaine addicts with PTSD may use the drug to increase positive moods and increase a personal sense of esteem.

In general, this research indicates that PTSD predates the onset of alcohol and drug abuse even though in a considerable number of cases SUD can precede PTSD onset (Chilcoat & Menard, 2003). Findings from prospective studies suggest that patients attempt to manage their thoughts and emotions around traumatic event(s), including feelings of over-arousal and emotional numbing. The results of large-scale studies such as the NCS and patient anecdotal accounts of their PTSD support this hypothesis, particularly among women where PTSD frequently develops prior to SUD or occurs in parallel (Stewart et al., 1998; Stewart & Conrod, 2003; Jacobson et al., 2001).

For Kofoed et al. (1993), the nature of the trauma itself may predict the type of problems most likely to develop and that a self-medication explanation may not apply universally. For example, among veterans who witness grotesque death/injury and atrocities, substance abuse/dependencies often do develop along with their PTSD but in other instances trauma exposure and alcohol/drug behaviors are not related. The problem for Kofoed et al. is that the self-medication model has been used to argue that by treating the primary disorder of PTSD that substance abuse problems will also resolve. They point to a lack of empirical data or even anecdotal support for this position. Meisler (1996), as
well, pointed to studies suggesting a parallel onset of substance abuse and PTSD contradicting somewhat the self-medication hypothesis. In his view, among women substance abusers the traditional notion of self-medication seems to hold better.

**Substance abuse prolongs or exacerbates PTSD**

The findings above are equivocal in that they are also consistent with the hypothesis that the cycle of substance intoxication-withdrawal can exacerbate PTSD symptoms, including sleep disturbance and exaggerated startle (Stewart et al., 1998). Jacobson et al. (2001) concluded that for PTSD-SUD patients, particularly those addicted to CNS depressants, the physiologic arousal resulting from withdrawal may be intolerable due to the additive effects with pre-existing arousal arising from PTSD. As well, alcohol may serve to maintain the disorder by interfering with the natural “working through” process and habituation to traumatic memories (Stewart & Conrod, 2003). In terms of specific susceptibilities, those PTSD patients who tend to be physiologically reactive (i.e., experience more somatic symptoms of anxiety) may prefer, and thus become dependent on, drugs with arousal-dampening properties such as alcohol; in contrast, those with less severe levels of arousal-related PTSD symptoms might be more likely to prefer arousal-enhancing effects such as cocaine (Stewart et al., 1998).

In summary, while there are continuing debates in the literature over the hypothetical linkages between PTSD and SUDs, the majority of researchers tend to support a self-medication model. As discussed in the following, this position is reflected in discussions of poor treatment outcomes for PTSD patients involved in traditional addiction treatment programs.

**TREATMENT OUTCOMES WITH PTSD AND SUD**
Consistent with the self-medication model, patients with PTSD may be at a higher risk to develop Type II alcoholism (Cramer, 2002). This form of alcohol dependence often has an early onset and is a more severe form of addiction. These patients tend to relapse more quickly, drink more often, and have a higher number of negative consequences related to drinking than their non-PTSD counterparts (Brown, 2000). Brown (2000) cited findings from Zlotnick et al.’s (1999) 5-year study wherein all PTSD patients treated for SUD had returned to substance use behaviors. In her research with women in hospital-based addiction treatments, over a 6-month follow-up, Brown (2000) reported that approximately 50% of the women relapsed to alcohol and/or drugs but interestingly approximately 25% had remained abstinent and were in remission from their PTSD diagnosis. Ouimette, Ahrens, Moos, and Finney (1998) reviewed treatment outcomes from 21-day and 28-day addiction treatment programs based on CBT, AA or CBT/AA combinations. Overall, patients with PTSD-SUD who completed treatment continued to report psychological distress suggesting continued likelihood of negative outcomes (Ouimette et al., 1998). The findings indicated that higher number of treatment sessions and inclusion of a family component were linked with more effective coping and less psychological distress among patients.

In their one-year follow-up study of patients in a methadone maintenance program, Clark, Masson, Delucchi, Hall, and Sees (2001) reported that remission of PTSD was associated with better substance abuse outcomes but that remission from substance abuse was not predictive of improvements on PTSD outcomes. Similarly, Brown, Stout, and Gannon-Rowlsy (1998) compared outcomes among 51 women and 44 men over a 6-month follow-up. Changes in PTSD symptoms appeared to have a greater
impact on drinking outcomes rather than the other way round. Dansky, Brady, and Saladin (1998) followed cocaine addicted patients over a 3-month period and also reported that improvements in drug use severity were linked with improvements in PTSD symptoms, especially for symptoms in the avoidance and hyperarousal clusters. In a well controlled study, Coffey et al. (2002) investigated links between negative emotions and increases in drug/alcohol cravings and relapse rates. They concluded that poor outcomes for PTSD-SUD patients may be related directly to the presence of intrusive symptoms that trigger cues to drink and where drug cues are part of the trauma (e.g., being sexually assaulted during a bad drug deal).

Results from a Canadian study of a community-based substance abuse program among participants (61 males and 30 females) found that over half of patients met criteria for a PTSD diagnosis (Bonin, Norton, Asmundson, Dicurzio, & Pidlubney, 2000). Consistent with Brown’s (2000) conclusions, Bonin et al. advised that all patients entering addiction treatment should be screened for PTSD. The failure by addiction staff to identify or to refer patients with PTSD represents a serious concern and likely contributes to increased feelings of shame and mistrust among these patients (Brown et al., 1998). Brown, Stout, and Meuller (1999) reported that the majority of PTSD-SUD patients (53%) favor concurrent treatment compared with programs that treat substance abuse before PTSD (28%) or treating trauma and then substance abuse (20%).

Drug treatments have also been found to be effective with PTSD-SUD patients. Naltrexone has been found in a number of studies to help with drug/alcohol cravings. A recent trial suggested that it may also help patients with dissociative symptoms (Department of Veterans Affairs, 2002).
In sum, while there is some evidence that traditional addiction programs and 12-step involvement can be potentially beneficial for PTSD-SUD patients (see Moggi, Ouimette, Moos, & Finney, 1999), there is a need to attend to the particular needs of trauma survivors as they relinquish their reliance on alcohol and drugs. In the next section, conceptual issues around “integrated” treatments are discussed. Several of these PTSD-SUD programs are reviewed along with preliminary outcome data.

MODELS OF INTEGRATED TREATMENTS

Many people continue to experience significant shame and guilt around traumatization that prevents them from coming forward for help. Often, they avoid medical care and attempt to manage on their own in the misguided hope that symptoms will dissipate in time (Foa et al., 2000). As noted, a substantial number of these people compound their problems by resorting to alcohol and drugs. In terms of available treatments for these patients, there are few well-controlled studies of programs that treat PTSD-SUD and as yet there exist no formal treatment guidelines pertaining to the treatment of comorbid PTSD-SUD (Foa et al., 2000; Ouimette et al., 2003).

In terms of traditional interventions, researchers and PTSD clinicians are wary of standard addiction treatments that require patients to “tell their stories”. Among PTSD sufferers, this expectation can trigger trauma reactions and subsequent drug/alcohol relapse. Successful completion of these addiction treatment programs does not guarantee continued abstinence for these patients since many of them continue to experience chronic psychological distress (e.g., depression and anxiety) which often leads back to alcohol use for symptom relief (McLellan, Grissom, Brill, Durell, Metzger, & O’Brien, 1993). Conversely, programs that focus on trauma work without treating substance abuse
disorders have high drop out rates because of patient inability to tolerate negative affect generated by therapeutic exposure work (Stewart et al., 1998). In response to these concerns, many researchers consistently call for the development of integrated interventions (Jacobson et al., 2001; Stewart et al., 1998). A fundamental concern voiced by many clinicians centers around the question of when to treat the SUD and when to treat the PTSD. While Ouimette et al. (2003) have found that successful PTSD treatment often contributes to successful remission of both disorders, many researchers believe the disorders to be interwoven and at best they both need to be addressed within concurrent approaches. Unfortunately, in many instances the disorders continue to be viewed and treated as separate problems or of secondary concern to the presenting problem (Lehman, Myers, & Corty, 2000; Ouimette et al., 2003).

In terms of symptom recognition and appropriate diagnosis, on the addiction front, many substance abuse workers either are not trained to conduct comprehensive assessment or they simply do not conduct screening of outside issues such as trauma and PTSD. Even when there is an identified diagnosis, traditional interventions are inflexible and cannot respond to the needs of patients with serious mental health concerns. Similarly, on the PTSD clinical front, trauma counselors through their own discomfort in challenging patients, sometimes accept substance use as a relatively benign coping strategy (Meisler, 1996). Alternatively, the use of alcohol/drugs may be seen as a temporary impediment to trauma work, producing a significant demand for sobriety before beginning exposure work or other trauma specific interventions. For many patients, this expectation frequently ends in failure. Consequently, patients are trapped in a cycle of symptom resistance, emotional avoidance, and social isolation and return again
to alcohol and drugs to manage these problems.

Integrated treatments are espoused by many to be the preferred mode of treatment for co-occurring disorders (RachBeisel, Scott, & Dixon, 1999). Since the 1990s, a number of programs have been developed in the USA under the general description of integrated treatment programs for PTSD-SUD. While there are important differences between these various approaches as outlined below, there are also common structural and treatment timing decision points shared by these initiatives.

Addictions and trauma recovery integrated model (ATRIUM). This program is described as a cognitive, behavioral, and spiritual model based on traditional CBT components combined with a 12-step emphasis to address addiction and trauma issues (Miller, 2002). In describing this program, Miller admonishes trauma therapists who shun 12-step recovery programs because of their own lack of comfort. Under the ATRIUM program, there is a four-fold focus for patients: (1) Recognizing and reinforcing resilience; (2) Achieving abstinence; (3) Recognizing and healing wounds of nonprotection, and (4) Creating a connection with the world beyond the self or in other words instilling a spiritual component of reverence for life.

The program was developed initially to help sufferers of childhood trauma and emphasizes the importance of emotional and physical safety, similar to Najavits’ program described below. ATRIUM is a 12-week program that includes didactic work, written homework assignments, and group sessions focused on developing sobriety, learning to tell one’s life story in safe context and working to understand aspects of trauma reenactment in relationships with others and how to begin moving past those life scripts (Miller, 2002). There is a strong emphasis on working with bodily symptoms as is the
focus in other current therapies. The program was designed for groups but can be adapted for individuals.

**Substance dependency-post-traumatic stress disorder therapy (SDPT).** SDPT originated as a pilot program sponsored by the National Institute of Drug Abuse (NIDA) (Triffleman, Carroll, & Kellogg, 1999). SDPT is a 20 week, outpatient, individually-focused program broken into 2 components (Triffleman, 2000). Treatment goals include initiation of abstinence, maintenance of abstinence during the course of the PTSD treatment, and reduction of PTSD symptom severity. Patients meet twice weekly for the initial 12 weeks to work towards substance abstinence. There is an emphasis on coping strategies and relapse prevention, and education about PTSD. During Phase II (week 13 to 20), patients undertake PTSD symptom-focused treatment with a continuation of attention to substance issues (Triffleman, 2000). SDPT is an adaptation and integration of cognitive-behavioral and coping skills treatment for substance abuse, stress inoculation training, and in vivo exposure.

SDPT is designed as a stand-alone therapy that can be used with adjunctive substance-abuse-related medication therapy (use of opiate agonists or antagonists). Regular urine toxicology is an integral treatment component (Triffleman et al., 1999). In terms of other foci in therapy, Triffleman et al. advocate that therapists have an understanding of psychodynamic principles such as projection, resistance, transference, and countertransference to guide their internal framework but they do not support explicit interpretation of the transference relationship. Patients with active severe depression, hypomania, or mania are not accepted into this program until controlled by medication. Preliminary data indicates that clients who are successful in the first phase of treatment
are better able to cope with trauma exposure work. Conversely, patients who are not able to abstain from substances do not appear able to tolerate exposure work during the second phase of treatment (Triffleman, 2000). In a controlled clinical trial of the program (N=19) comparing SDPT with 12-step facilitation therapy (program with a focus on the 12 steps of AA), however, no significant differences were found in terms of patient outcomes. At present, an open trial of the program is underway (Coffey, Dansky, & Brady, 2003).

**Seeking Safety.** The Seeking Safety program was developed by Lisa Najavits and her colleagues to help women to address urgent SUD and PTSD concerns. The program is a 25-session, first stage, CBT based intervention (Navajits, Weiss, & Liese, 1996; Navajits, 2002). There is an emphasis on emotional and physical safety, self-care, homogeneous group membership (the program has been modified to allow for individual participation, as well), low conflict, didactic content, and moderate levels of group cohesion. The first component of the program focuses on achieving abstinence within a CBT orientation versus explorative work, interpretations, or insight. The belief is that these cognitive and behavioral strategies allow patients to gain control over both SUD and PTSD symptoms as a first step (Navajits et al., 1996). The treatment manual (Najavits, 2002) lays out specific instructions, guidelines and patients handouts on a session-by-session basis.

While developed originally to help rape survivors, over time the program has been modified for other female populations: women in prison, inner-city women, and outpatient women (Najavits, 2003). Available data from one study showed improvements in substance abuse outcomes, improvements in depression and social adjustment, however, no changes were observed in PTSD symptoms during involvement in the
program (approximately 3 months) (Ouimette et al., 2003). Patient comments were favorable for the program’s focus on abstinence, coping skills, and safety general but they were dissatisfied with the short length of treatment and the requirement to attend groups (Ouimette et al., 2003). Other reviews have pointed to concerns over the high patient drop-out rate from the program. A program trial is underway for Vietnam veterans at 10 hospital sites in the US.

**Transcend program.** The “Transcend” program was developed with Vietnam veterans with PTSD and substance dependence problems. It is a 12-week, group format, partial hospitalization intervention designed to help patients develop mastery over impulses, accept responsibility for change, decrease shame and increase overall self-efficacy. Groups are fixed and closed with a maximum of 10 members. The 12-week program is broken into 2 phases - Phase 1 (weeks 1 to 6) addresses skill development and group cohesion and Phase 2 (weeks 6 to 12) addresses trauma processing. Patients are required to attend an average of 14 hours of group therapy per week, addiction recovery counseling, and random urine testing as part of program. Transcend is based on the concept of graduated therapeutic intensity that begins slowly with a focus on skill development and achieving abstinence and increasing in intensity towards trauma work.

Development of the program is outlined in published articles and treatment manuals (see Donovan & Padin-Rivera, 1999; Donovan, Padin-Rivera & Kowaliw, 2001; Donovan, Padin-Rivera, & McCormick, 1997). Donovan et al. (2001) reviewed outcomes from traditional treatments for PTSD that do not address SUD (e.g., individual therapy, imaginal flooding, pharmacotherapy, and direct exposure) and found that although these interventions sometimes showed initial promise, longer-term improvement
rates have been disappointing (Donovan et al., 2001). In fact, they reported that patients treated in long-term residential settings for PTSD do not show significant changes in symptoms or social functioning at follow-up (up to 1 year). In some cases, patients become worse in these PTSD-only programs. Conversely, they argue that treatment of the SUD allows for better PTSD outcomes.

Data from one study with 46 combat veterans with PTSD-SUD showed a reduction in overall PTSD symptomology and addictive behaviors at 12-weeks, 6-month and 12-month follow-up (Donovan et al., 2001). Donovan et al. attribute these positive outcomes to the influence of group involvement to help break down emotional and social isolation and to the trauma processing component that helps patients develop understanding and compassion for what has happened to them and moving beyond a victim role as opposed to simple desensitization of events.

The programs described above have been developed recently. Consequently, the empirical evidence in support of integrated efforts continues to emerge. As part of this emerging empirical base, important clinical and treatment issues for PTSD-SUD patients also are being identified.

CLINICAL TREATMENT ISSUES AND THE EVIDENCE

Ouimette et al. (2003) reported that nearly 1/3 of PTSD clinicians view addiction as a contraindication to exposure techniques. Even so, in the PTSD treatment world, there are common concerns that these patients cannot benefit from affiliation with self-help groups such as Alcoholic Anonymous because they risk retraumatization by retelling their story. As well, there is often concern that AA members may advise their patients to stop their medications. Hence, self-help is frequently not discussed with patients
(Ouimette, Humphreys, Moos, Finney, Cronkite, & Federman, 2001). Ouimette et al. (2001) investigated the veracity of these beliefs by following treatment outcomes among PTSD-SUD patients and reported that one-quarter to one-third of patients were regularly involved in self-help. Those patients with high religiosity and who accepted an alcoholic/addict identity were more likely to benefit. Those who accepted disease model beliefs and who wanted abstinence at baseline also were more likely to be involved with AA. This pattern of stable remission was observed during a 2-year follow-up. Conversely and importantly, patients who did not adopt an identity consistent with 12-step philosophy showed markedly more distress (Ouimette et al., 2001). In this study, direct canvassing of AA members found overwhelmingly (93%) that these programs are very accepting of the need for medication usage.

Ouimette and her colleagues have reported short-term improvements by PTSD-SUD patients involved in traditional addiction treatment programs in the absence of trauma specific components (Ouimette et al. 2003). These benefits, however, do not appear to hold in the long-term. For Stewart and Conrod (2003), given the mediating role of PTSD symptoms, standard SUD treatment may not be effective in reducing substance-related problems when comorbid with PTSD (Stewart & Conrod, 2003). The research suggests that PTSD patients often employ emotional discharge to vent their distress (including the use of substances) instead of employing strategies learned during SUD treatment. Among these patients, addiction treatment components linked with improved psychological status are high levels of structure and organization within the addiction treatment program along with substance abuse counseling, family counseling and greater use of self-help during treatment (Ouimette, Brown, & Najavits, 1998).
The timing of trauma work and addiction treatment has been an ongoing point of discussion in the literature (see Department of Veterans Affairs, 2002). For Triffleman (2000), this timing controversy represents an ongoing debate. Those who advocate immediate trauma treatment argue that the failure to address distressful symptoms early contributes to higher rates of patient drop out. Those who advocate later management of the trauma (typically after 6 months of abstinence) argue that since the patient has sought treatment for addiction, addressing other issues at the same time presents a threat to them (Triffleman, Carroll, & Kellogg, 1999). In terms of the specific question of whether sequencing of treatments for SUD and PTSD is more effective than simultaneous therapy for these problems, several conclusions were drawn by the Department of Veterans Affairs (2002) in the USA: (1) The research by Donovan et al., (2001) suggests that an integrative program to treat chronic combat PTSD-SUD can be effective; (2) Triffleman’s (2000) research did not find differences between SDPT and Twelve Step Facilitation Therapy with PTSD-SUD patients; and (3) Research by Ouimette et al. (2001) suggests that SUD programs without a trauma focus can be of benefit to some PTSD-SUD patients, particularly among patients who can identify with AA.

CONCLUSIONS AND PRELIMINARY RECOMMENDATIONS

Despite the wide level of support for developing integrated approaches to treating patients with PTSD-SUD, Ruzek (2003) cautions that the empirical evidence for simultaneous treatment is tenuous. The Expert Consensus Guidelines have recommended screening PTSD patients for SUD at intake and reassessing them periodically (Ouimette et al., 2003). In terms of treatments for PTSD-SUD, the guidelines recommend anxiety management and they encourage the use of CBT and psycho-education. Treatment
modalities supported by the guidelines for SUD include cognitive, behavioral, psychodynamic-interpersonal, group-family and self-help (Ouimette et al., 2003). In the absence of specific guidelines for treating PTSD-SUD patients, Ouimette et al. (2003) outlined several recommendations: (a) SUD patients should be routinely screened for trauma and PTSD, (b) PTSD-SUD patients should be referred for concurrent treatment; (c) where appropriate, patients should be encouraged to attend self-help; and (d) providers need to have continuing outpatient contact over time.

In general, then, several broad conclusions can be made based on the literature reviewed. Overall, PTSD-SUD patients appear to respond less favorably to standard SUD-focused treatments. PTSD-SUD patients appear to suffer more frequent and more severe relapses following SUD treatment compared with non-PTSD patients. Preliminary evidence suggests that after patients are stabilized and successful in PTSD-focused treatments, there is a significant reduction in their SUD symptoms.

In a recent review, the Department of Veterans Affairs (2002) in the US, noted the following conclusions and recommendations. Several of these observations may also apply within a Canadian context. Clinicians treating veterans should routinely screen for addiction and trauma. It is important also to address substance abuse triggers as part of interventions with this group. Overall, 12-step programs without a trauma focus can be useful in treating some patients with comorbid PTSD-SUD (Donovan et al., 2001; Ouimette et al., 2001; Ruzek, 2003; Triffleman, 2000). In terms of recommended integrated interventions, preliminary results of the Transcend program with veterans are encouraging for addressing combat-related PTSD and SUD (Department of Veterans Affairs, 2002).
Much of the literature reviewed herein describes the situation in the United States and likely does not reflect exactly the situation for Canadian civilian and military populations. Even so, extrapolation of the available data points to potential directions for consideration by the Treatment Standards Committee membership. One clear conclusion seems to be that the status quo of providing relatively independent programming needs to be reviewed systematically in terms of existing outcomes for Canadian military PTSD-SUD patients.
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