Treatment for the Dual Diagnosis of Posttraumatic Stress and Substance Use Disorders

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Introduction

"I just felt so ugly, hateful and evil. I hated myself. There was nothing good in me. I didn't know I was someone. I would always look down. But when I drank, it made me feel confident, secure and happy. It made me feel all the things I was not," (quoted in Stamm, pp. 59–61, 2002).

Maria, like many others with posttraumatic stress disorder (PTSD) and substance use disorder (SUD), attempted to use substances to escape the pain of trauma. She had a severe history, with childhood sexual abuse by a brother and physical and emotional abuse by her mother. She began substance use early (alcohol, cocaine, and heroin) and eventually prostituted to obtain money for drugs. After a while, she no longer got high from substances. She tried Alcoholics Anonymous as well as multiple detoxifications and treatment programs but was unable to stop. Finally, at age 27 in yet one more program, she met a therapist who helped her to work on her trauma and substance abuse at the same time. She calls therapy her "foundation" and has achieved eight years of sobriety (paraphrased from Stamm, 2002).

Learning Objective

Clinicians will explore the relationship between posttraumatic stress disorder (PTSD) and substance use disorder (SUD), including rates, assessment challenges, specific psychotherapies for this dual diagnosis, and key treatment concerns.

There are innumerable client stories—and many different types of trauma, substance use, and methods of healing. However, it is clear that substance abuse and trauma are closely linked for many. Trauma, defined by the DSM-IV (American Psychiatric Association, 1994) as the experience, threat, or witnessing of physical harm, includes a variety of experiences such as combat, childhood physical or sexual abuse, a serious car accident, life-threatening medical illness, general disasters such as hurricanes or tornados, and manmade disasters such as terrorist attacks and chemical spills. **Posttraumatic stress disorder is the psychiatric diagnosis most commonly associated with trauma and includes three core sets of symptoms: intrusion (e.g., flashbacks and nightmares), avoidance (e.g., not wanting to talk about the event), and arousal (e.g., heightened startle reflex and hypervigilance).** *Substance use disorder* refers to *substance abuse*, a less severe form of the disorder, and *substance dependence*, a more severe form. Criteria for SUD are provided in detail in the DSM-IV and include symptoms such as unsuccessful efforts to cut down on substance use, taking the substance in larger amounts or longer periods of time than intended, and recurrent substance use in situa-

tions that are physically hazardous (such as driving a car).

According to epidemiologic research, among men who experience PTSD in their lifetime, 52% develop alcohol use disorder and 35% develop drug use disorder. Among women, the rates are 28% and 27%, respectively (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). In clinical settings, the rates of co-occurring PTSD and SUD are higher. **For example, in substance abuse treatment, 12% to 34% of clients are estimated to have current PTSD; for women in particular, the rates are 30% to 59% (Najavits, Weiss, & Shaw, 1997).** Various subpopulations have particularly high rates of trauma and SUD, including adolescents, veterans, prisoners, gays and lesbians, the homeless, rescue workers such as firefighters and police, victims of domestic violence, and prostitutes (Davis & Wood, 1999; Jacobsen, Southwick, & Kosten, 2001; Najavits, et al., 1997; North, et al., 2002; The Substance Abuse and Mental Health Services Administration, 2001; Smith, North, & Spitznagel, 1993; Tarter & Kirisci, 1999; Teplin, Abram, & McClelland, 1996; all cited in Najavits, in press-a).

Individuals with the dual diagnosis of PTSD and SUD, compared to those with either disorder alone, are known to evidence worse outcomes in treatment, more Axis I and II disorders, increased HIV risk, legal and medical problems, suicidality and self-harm, lower work functioning, and increased risk of future trauma (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Hien, Nunes, Levin, & Fraser, 2000; Najavits, Gastfriend et al., 1998; Ouimette, Finney, & Moos, 1999: all cited in Najavits, in press-a).

Assessment of PTSD and SUD

Assessment of PTSD and SUD presents a variety of challenges. **For example, PTSD tends to be misdiagnosed and underdiagnosed, both generally (e.g., Davidson, 2001) and in substance abuse settings (e.g., Dansky, Roitzsch, Brady, & Saladin, 1997).** This problem stems from a variety of factors, including client shame about reporting trauma, clinician reluctance to ask about trauma, and a greater focus on co-occurring diagnoses for which clear medications are available (e.g., major depression) or which may appear similar in some ways to PTSD (e.g., borderline personality disorder). Similarly, in mental health settings, SUD may be misdiagnosed or underdiagnosed due to the clients' denial and minimization, clinicians' lack of familiarity with SUD, and other factors.

Second, it is important to be aware of potential implications of the PTSD and SUD assessment. Clients may either increase or decrease their symptom reporting if there are secondary gain issues (monetary compensation for PTSD, regaining custody of a child based on improvement in SUD) or legal concerns (mandatory reporting of abuse of a child, an imminent court appearance for drug charges). Treatment decisions also may be affected by results of the assessment. For example, a client who reports significant psychological problems, such as suicidality, may be denied entry into a substance abuse treatment program until stabilized. A client who reports SUD may be denied entry into a mental health program until a certain period of abstinence from substances is attained. Such "split systems" (lack of integration of mental health and SUD services) have historically been a notable concern for dual-diagnosis clients (Triffleman, 1998).

Third, substance use or withdrawal from substances may impact client reporting of PTSD symptoms. Several studies, for example, have found associations between type of substance and prominence of particular PTSD symptoms (e.g., arousal symptoms prominent for both cocaine dependence [Najavits, et al., 2003] and alcohol dependence [Stewart, Conrod, Pihl, & Dongier, 1999]). Use or withdrawal may also impair a client's memory and may either dampen or increase the intensity of symptoms. Based on such concerns, some writers have argued that assessment of PTSD should occur only after a certain length of substance withdrawal (Read, Bollinger, & Sharansky, 2003). Others, however, believe that the PTSD diagnosis itself is quite robust even during substance use or abstinence (in contrast to specific symptoms that may be somewhat heightened or diminished) and that the greater

danger is underdiagnosis or misdiagnosis of PTSD (e.g., Najavits, in press-a). Thus far, no studies appear to address this issue.

Several recommendations for assessment of PTSD and SUD are as follows (Najavits, in press-a):

- **Routinely assess for trauma, PTSD, and substance abuse.**
- **If a client shows up high or inebriated, delay the assessment.**
- **Provide a supportive yet direct style to help clients feel safe in revealing both their PTSD and SUD.**
- **Ask minimal information to assess trauma. Excessive detail may evoke emotions that the client is unprepared to handle.**
- **Give clients feedback about results of the assessment if they are interested (e.g., presence of the PTSD and SUD diagnoses). Such information can be an important step in helping them understand their problems.**
- **Assess for trauma and PTSD even during a phase of active substance use or withdrawal, but plan to reconfirm the diagnosis later (e.g., after four to six weeks of abstinence).**
- **Note that assessment of trauma alone is insufficient. It is also important to assess whether the client has any current symptoms or diagnosis related to the trauma, such as PTSD.**
- **For a listing of websites with measures that can be downloaded directly, see Najavits, in press-a; also www.seekingsafety.org provides links to several brief, free self-report measures that can be directly downloaded.**

Specific Treatments

Psychotherapy for the dual diagnosis of PTSD and SUD has advanced considerably over the past decade. A number of models have been developed specifically for the dual diagnosis, and some have undergone empirical evaluation. This section offers a description of these models and, if applicable, their research results. Information about psychopharmacologic interventions are not addressed but can be obtained elsewhere (e.g., Brady, Sonne, & Roberts, 1995. Note that the material in this section is drawn from the Treatment Improvement Protocol on Trauma and Substance Abuse, with permission (Center for Substance Abuse Treatment, under review).

Models that Have Been Empirically Studied

This section describes psychotherapy models designed for the dual diagnosis of PTSD and SUD for which published outcome results are available.

Seeking Safety:

Description

Seeking Safety is a present-focused therapy to help clients attain safety from both PTSD and substance abuse. The treatment is available as a book (Najavits, 2002), providing clinician guidelines and client handouts. Seeking Safety was designed for group or individual format, females and males, a variety of settings (e.g., outpatient, inpatient, residential), and for both substance abuse and dependence. Seeking Safety has also been used with clients who have a trauma history but do not meet criteria for PTSD. It has been studied with both adults and adolescents.

Seeking Safety consists of 25 topics that address cognitive, behavioral, interpersonal, and case management domains. The treatment was designed for a high level of flexibility in clinical settings. Topics can be conducted in any order, using as few or as many as are possible within the clients' length of stay, and by a wide variety of counselors (e.g., paraprofessionals and professionals). The topics are: *Introduction/Case Management; Safety; PTSD: Taking Back Your Power; When Substances Control You; Honesty; Asking for Help; Setting Boundaries in Relationships; Getting Others to Support Your Recovery; Healthy Relationships; Community Resources; Compassion; Creat-*

ing Meaning; Discovery; Integrating the Split Self; Recovery Thinking; Taking Good Care of Yourself; Commitment; Respecting Your Time; Coping with Triggers; Self-Nurturing; Red and Green Flags; Detaching from Emotional Pain (Grounding); Life Choices; and Termination. See also related articles (e.g., Najavits, 2000; Najavits, in press-b) and the website www.seekingsafety.org.

Empirical Research

Seeking Safety, at this point, is the most studied therapy for trauma/PTSD and substance abuse, with seven completed outcome studies (including two randomized trials), all evidencing positive results. The studies were (1) outpatient women using group modality (Najavits, Weiss, Shaw, & Muenz, 1998); (2) women in prison, in group modality (Zlotnick, Najavits, Rohsenow, & Johnson, 2003); (3) low-income, mostly minority women, in individual format (Hien, Cohen, Litt, Miele, & Capstick, under review); (4) adolescent girls, in individual format (Najavits, Gallop, & Weiss, under review); (5) outpatient men traumatized as children, in individual format (Najavits, Schmitz, Gotthardt, & Weiss, under review); (6) women in a community mental health setting, in group format (Holdcraft & Comtois, in press); and (7) men and women veterans, in group format (Cook, Woody, & Kane, under review).

In the six studies that reported on substance abuse, improvements were found in that domain. Similarly, the six studies that included assessment of PTSD and/or trauma-related symptoms found improvements in those areas. Improvements were also found in a variety of other areas, such as general psychiatric symptoms, social adjustment, suicidal thoughts and plans, problem solving, sense of meaning, quality of life, and depression. Treatment attendance and satisfaction were high. Four of the studies had follow-up periods after treatment ended and showed maintenance of some key gains (Hien, et al., under review; Najavits, Weiss, Shaw, & Muenz, 1998; Najavits, Gallop, et al., under review; Zlotnick, Najavits, & Rohsenhow, in press). Five of the studies were pilots, while two were randomized controlled trials (Hien, et al., under review; Najavits, Gallop, & Weiss, under review). In the trial by Hien et al. (under review), Seeking Safety performed as well as Relapse Prevention treatment, and both significantly outperformed a non-randomized treatment-as-usual control condition (standard substance abuse and mental health treatment). In the Najavits, Gallop et al. study (under review), Seeking Safety outperformed treatment-as-usual in the community for outpatient adolescent girls.

Finally, it can be noted that two of the studies combined Seeking Safety with other manual-based approaches. The study of men combined Seeking Safety with Exposure-Therapy-Revised, an adaptation for substance abuse clients of Exposure Therapy for PTSD (Najavits, Schmitz et al., under review). The study of women in a community mental health center (Holdcraft & Comtois, in press) combined Seeking Safety with Linehan's Dialectical Behavior Therapy (Linehan, 1993).

Concurrent Treatment of PTSD and Cocaine Dependence:

Description

Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD) is a 16-session, twice weekly individual outpatient psychotherapy designed for women and men with comorbid PTSD and cocaine dependence (Back, Dansky, Carroll, Foa, & Brady, 2001). CTPCD combines both imaginal and in vivo exposure therapy for the treatment of PTSD plus elements of CBT for substance dependence (Carroll, 1998; Kadden, et al., 1995; Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002). To balance the dual needs of sobriety skill building and trauma treatment, the first five sessions focus on coping skills for cocaine dependence. Session six makes the transition to use of exposure therapy, which begins in session seven, and is combined with a CBT topic for the treatment of substance abuse.

Empirical Research

One uncontrolled pilot study on CTPCD has been completed (Brady, Dansky, Back, Foa, & Caroll, 2001).

Treatment completers (defined as having attended 10 or more sessions; 38.5% of the 39 clients enrolled) evidenced reductions by the end of treatment in all three PTSD symptom clusters (intrusion, avoidance, and arousal), cocaine use, depression, and psychiatric and cocaine use severity. Improvements in PTSD symptoms and cocaine use were maintained over a 6-month follow-up. Those who dropped out (n = 61.5%) had significantly lower education and higher PTSD avoidance symptoms. With some modifications, CTPCD has been used in a variety of settings, including inner-city community mental health centers (Coffey, Schumacher, Brimo, & Brady, in press).

Substance Dependence PTSD Therapy:

Description

Substance Dependence PTSD Therapy (SDPT; Triffleman, Carroll, & Kellogg, 1999) **is an integration of empirically validated treatment approaches for substance dependence** (Carroll, 1998; Carroll, Rounsaville, & Keller, 1991) **and trauma (Stress Innoculation Therapy and in vivo exposure).** SDPT was designed for both genders and for patients with diverse trauma histories. SDPT is a structured 5-month, twice-weekly individual treatment with two phases. SDPT has recently been renamed ARTS.

Phase I is "trauma-informed, addiction-focused treatment" and consists of five treatment modules taken largely from CBT for substance use (Carroll, 1998; Carroll, et al., 1991; Kadden, et al., 1995; Monti, et al., 2002). Modules are: Introduction to SDPT, Coping with Craving and Drug Use Triggers, Relaxation Training, HIV Risk Behaviors, and Anger Awareness and Management. Modules in phase I emphasize the application of these topics for both the PTSD and addiction.

Phase II is a "trauma-focused, addictions-informed phase," which aims to reduce PTSD symptoms while continuing active attention to the addiction. The first portion of phase II consists of a modified version of Stress Innoculation Therapy (SIT). SIT teaches coping skills and cognitive restructuring strategies to reinterpret cognitive distortions about trauma-related and other stressful stimuli, including trauma-related therapy sessions. In preparation for the in vivo exposure, clients are taught strategies to address avoided situations, including how to approach an avoided situation, how to confront the situation, skills to employ if overwhelmed by an avoided situation, and, finally, how to deal with the aftermath that may follow. During the "anti-avoidance" phase of treatment, SIT is combined with in vivo exposure, as described above, to reduce cognitive, emotional, and physiological reactivity to trauma-related stimuli. In vivo exposure is administered in the form of a desensitization hierarchy. Throughout treatment, urinalysis for continuing substance use is undertaken on a weekly to twice-weekly basis. Throughout phase II, therapists actively monitor continued substance use and substance craving, both in relation to the patient's usual triggers as well as in relation to therapy sessions and therapy homework.

Empirical Research

A pilot study evidenced reduction in PTSD severity by the end of treatment. Although substance abuse symptoms did not decline significantly by the end of treatment, they had declined at a three-month follow-up (Triffleman, 2000).

Transcend:

Description

Transcend is a 12-week partial hospitalization treatment program for Vietnam veterans with PTSD and substance abuse disorder (Donovan, Padin-Rivera, & Kowaliw, 2001). It consists of 10 hours per week of group treatment, mandatory attendance in a substance abuse rehabilitation program, and supplementary activities (e.g., volunteer community service). Six weeks focus on skills development and 6 weeks on trauma processing, based on a combination of concepts derived from constructivist, existential, dynamic, cognitive-behavioral, and 12-step theories.

Empirical Research

A pilot study provides data on 46 male veterans who completed the Transcend program. All were required to have 30 days of substance abstinence before beginning the project, verified by urinalysis. Results showed less intense and less frequently occurring PTSD symptoms and fewer days of substance use by the end of treatment, with gains sustained at 6- and 12-month follow-up (Donovan et al. 2001).

Other Models

This section describes psychotherapy models designed for the dual diagnosis of PTSD and SUD, for which published outcome results are not yet available.

Addiction and Trauma Recovery Integration Model:

The Addictions and Trauma Recovery Integrated Model (ATRIUM; Miller & Guidry, 2001) integrates cognitive-behavioral and relational treatment through an approach that emphasizes mind, body, and spiritual health. ATRIUM, a 12-week model for individuals and groups, provides a blend of psychoeducational, process, and expressive activities. Information is provided on the body's response to addiction and traumatic stress as well as the impact of trauma and addiction on the mind and spirit. Specifically, information is provided on anxiety, sexuality, self-harm, depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection.

Helping Women Recover: A Program for Treating Addiction

Helping Women Recover (Covington, 1999; Covington, 2000) is a treatment that integrates theories of women's psychological development, trauma, and addiction treatment to meet the needs of women with substance abuse. While designed for group modality in residential, outpatient, and inpatient settings, it can be adapted for individual format. It consists of 17 sessions within four modules that women in treatment identify as triggers for relapse: self, relationships, sexuality, and spirituality. The model includes a facilitators guide and A Woman's Journal, the coordinated workbook, which contains self-tests, checklists, and exercises. In addition, revised editions of both the facilitator's guide and client journal are designed for incarcerated women. See also the website www.stephaniecovington.com.

Trauma Adaptive Recovery Group Education and Therapy:

Trauma Adaptive Recovery Group Education and Therapy, or TARGET (Ford, Kasimer, MacDonald, & Savill, 2000), is a present-focused emotion/information processing and strengths-based approach to education and skills training for trauma survivors. The goal of TARGET is to help trauma survivors understand how trauma changes the body and brain's normal stress response into an extreme survival-based alarm response that can become PTSD and to help them learn a seven-step approach to changing the PTSD alarm response into a less distressing and more adaptive response. TARGET addresses substance abuse and PTSD concurrently in every session, with a focus on addressing PTSD symptoms in order to simultaneously manage or reduce substance abuse symptoms (and to prevent relapse). TARGET can be presented in individual therapy or gender-specific psychoeducational groups and has been adapted for deaf individuals and translated into Spanish and Dutch. Regardless of format, the specifics of clients' traumas are not discussed during the program.

Trauma-Relevant Relapse Prevention Training:

This early model by Abueg and Fairbank (Abueg & Fairbank, 1991; Abueg, et al., 1994) was designed for inpatient veterans with PTSD and alcoholism. The treatment is based on lifespan developmental and social learning models to provide (1) a framework for understanding what has happened, (2) tools for effective coping, (3) an arena to experience the discomfort of previous coping mechanisms, and (4) practice of new skills. The program has three phases derived in part from the stages of change model of Prochaska and DiClemente (Prochaska, et al., 1994). Phase I focuses on solidifying

motivation for change through assessment, education, and interpersonal work. Phase II represents the action stage and incorporates exposure-based therapy in a developmental framework to address trauma issues. Phase III emphasizes maintenance and generalization of patients' learning via modified relapse prevention training. Although there has been mention in the literature of empirical study of this model (see Ruzek, Polusny, & Abueg, 1998), no results have thus far been published.

Treating Addicted Survivors of Trauma:

This model (Evans & Sullivan, 1995) is an integration of therapeutic approaches with a 12-step approach to the treatment of substance abuse. It is designed for the treatment of childhood abuse survivors who have substance use disorders and is based on a medical view of substance abuse as illness. The model assumes that the clients will accept the 12-step approach to treatment. It uses the principle of "safety first" as the overall therapeutic strategy and has five stages to guide the selection of appropriate treatment tactics to promote "dual" recovery. The stages include crisis, skill building, education, integration, and maintenance.

Other Models:

Several other models are described briefly but have not yet been manualized or empirically studied. These include Meisler's group therapy for PTSD and alcohol abuse (Meisler, 1999), Bollerud's model for inpatient units (Bollerud, 1990), and Trotter's book (Trotter, 1992).

General Treatment Themes

In addition to specific models of psychotherapy for the dual diagnosis of PTSD and SUD, some common themes can also be identified.

1. Integrated Treatment:

It is widely recommended that clients be treated for PTSD and SUD at the same time and, if possible, by the same program or therapist. It used to be said that clients needed to attain a period of sustained abstinence from substances before they could embark on PTSD treatment. This is called "sequential treatment," meaning that one disorder is treated first, then the other. However, all of the specialized treatments designed for the dual diagnosis, as described in the section above, attempt to address both disorders at once in an effort to maximize the likelihood that clients can succeed at their recovery from both. Clients too repeatedly express a preference to work on their PTSD at the same time (Brown, Stout, & Gannon-Rowley, 1998; Najavits, Sullivan, Schmitz, Weiss, & Lee, in press). However, thus far, no studies specifically have compared integrated versus sequential treatments. Studies have indicated, however, that integrated models for this dual diagnosis outperform "treatment-as-usual" in the community (e.g., Hien, et al., under review; Najavits, Gallop, et al., under review).

2. Psychoeducation:

Clients often have little or no knowledge of PTSD and its relation to substance abuse, despite having lived with these illnesses for many years. It is often highly therapeutic to learn about the diagnoses, how commonly they co-occur, and to identify gender differences and trauma-related symptoms (e.g., dissociation, self-harm, distrust, boundary problems, sexual problems). Such psychoeducation can help clients move toward a respectful awareness of their symptoms, rather than perceiving themselves as "crazy, lazy or bad" (Najavits, 2002). It can help them to see how their behavior, including substance abuse, makes sense in light of their trauma history.

3. Coping Skills:

Clients with this dual diagnosis often have poor coping skills. They may never have learned positive coping in their family of origin and may have diminished ability to cope due to the impact of PTSD and SUD. Substance abuse per se is widely understood, at least in part, as a misguided attempt to manage events, feelings, and triggers (Marlatt & Gordon, 1985). Other poor

coping includes self-harm (mutilating the body), passivity (letting life just "happen"), lack of goals, and relational disturbances such as power struggles. Thus, most treatments designed for this dual diagnosis place a strong emphasis on educating the client in a variety of new coping skills (see specific skills in the section above).

4. Trauma-Informed Treatment:

In addition to particular psychotherapy models, there is increasing focus on the need for treatment systems to be "trauma-informed" (Fallot & Harris, 2001). Even staff that does not conduct psychotherapy (e.g., administrators, support staff, paraprofessionals) can help improve the treatment atmosphere by learning about PTSD and its link to SUD. Typical themes of trauma-informed treatment include adapting policies to be sensitive to trauma (e.g., letting a client keep the lights on at night in a residential program), creating advanced directives (e.g., collaborating with the client to develop a plan for how to calm her if she becomes agitated), seclusion and restraint policies that do not reenact trauma (e.g., avoiding four-point restraints), and the use of a therapeutic style that takes trauma into account (e.g., emphasis on support, empathy, and empowerment).

5. Multiple Modalities:

Due to the complexity of this dual diagnosis and the many life problems associated with it (homelessness, poverty, medical problems, HIV risk, parenting issues, legal problems), the more modalities of treatment, the better. This may include referrals to 12-step self-help groups such as Alcoholics Anonymous, parent skills training, psychopharmacology, group therapy, day treatment, domestic violence counseling, etc. For an extensive discussion of case management for this population, see the chapter "Community Resources" in Najavits, 2002.

6. Countertransference:

Both PTSD and SUD tend to evoke strong countertransference responses by clinicians (Imhof, 1991; Pearlman & Saakvitne, 1995). These include overidentification with clients' suffering (e.g., secondary traumatization in which clinicians develop PTSD-like symptoms themselves), frustration and anger (e.g., when clients repeatedly relapse), power struggles (e.g., reenacting the trauma roles of victim, perpetrator, or bystander; Herman, 1992), and boundary lapses (e.g., excessive self-disclosure). Thus, helping clinicians to manage their emotional responses to these clients is a key aspect of successful treatment.

Conclusions

Helping clients work on both PTSD and SUD is a rewarding clinical endeavor, yet at times quite challenging. Rates of the dual diagnosis are substantial, as are the range of associated life problems (such as other co-occurring disorders, homelessness, self-harm, and HIV risk). The past decade has seen progress in descriptive studies of this population and outcome studies testing the new psychotherapies. However, research remains at an early stage. There are few controlled therapy trials for this population and as yet no published studies comparing integrated versus parallel or sequential treatments. More research and continued clinical innovation are warranted.

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