Commentary

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Integrated Approaches to Treating Psychological Trauma and Substance Abuse in Women: An Update

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Abstract

Trauma, which can result in PTSD, and substance abuse disorders often co-occur. Sometimes SUD exposes people to additional traumas. Sequential treatment which involves dealing with one disorder at a time has been ineffective in resolving the comorbidity of these disorders. More recently, an integrated approach that involves working with both disorders at the same time is showing positive results. Several integrated models have been developed and some of these models are outlined in this paper. Programs that include psychoeducation and structure for both clients and providers are likely to be most effective. Working closely with clients to establish treatment goals and expectations, and deciding what approach works best, play a major role in determining the success of any program. Future research is necessary to expand the many evidence-based and promising options for integrated PTSD and SUD treatments, in order to determine effectiveness of programs with more diverse and ethnic minority communities. More specifically, research is needed to examine the duration, scope, timing, and combination of components for optimal integration of PTSD and SUD treatment. Finally, medical providers can play an integral role in ensuring that patients, who suffer from both PTSD and SUD, are referred to receive additional services and appropriate resources.

Keywords: Trauma; PTSD; Substance abuse; Comorbidity; Integrated intervention

Commentary

Trauma occurs as a result of experiencing an event, or series of events, that is harmful and/or threatening and which has long-term adverse effects on physical, social, emotional, or spiritual functioning [1]. Many people who experience a traumatic event develop posttraumatic stress disorder (PTSD) and substance use disorders [2]. SUD can expose some individuals to further traumatic experiences; e.g. drug dependency may contribute to a woman remaining in an abusive relationship [3]. Approximately 46.4% of individuals with lifetime PTSD have comorbid SUD [4]. Among women, the relationship between PTSD and SUD is often bi-directional, meaning women with PTSD are more likely to experience comorbid SUD [5]. About 80% of women seeking SUD treatment report histories of sexual and physical assault [6]. Other research shows that one in seven women in the U.S. experience rape, a traumatic event that is associated with a wide range of mental health difficulties such as substance use disorders [7].

Moreover, women suffering from PTSD are more likely to engage in avoidance coping strategies, including substance abuse, to reduce symptoms of PTSD [8] (e.g. intrusive images, flashbacks, and difficulty sleeping). In fact, some researchers report that survivors of trauma may view substance abuse as "a vehicle," albeit a dangerous one, that allows them to dissociate and escape from the emotional pain of the trauma [9]. Compounding symptoms of PTSD and SUD have negative effects on people diagnosed with PTSD who respond less favourably to treatment as usual, use more health services, drop out of treatment, and are unlikely to continue with care [10].

Profile of women with co-occurring disorders

Epidemiological studies such as the National Comorbidity Survey indicate that women are more likely than men to develop posttraumatic stress disorder (PTSD) after trauma exposure [11]. A study of women diagnosed with PTSD found the majority of women were victims of childhood abuse and repeated or chronic trauma, generally older, more educated, and reported spending more days abusing alcohol [12]. Research suggests that different types of trauma lead to different negative psychological outcomes such as interpersonal, behavioral and emotion regulation deficits and substance abuse among women [13].

Treatment Models

The sequential model of treating SUD and PTSD dominated the clinical field for a period of time, based on the misconception that if the addiction is treated simultaneously with the trauma, the two would compete with each other and cause an exacerbation of symptoms [14]. The model has not been without problems. First, it ignored the co-morbidity of SUD and PTSD by assuming that abstinence will resolve comorbid

trauma-related disorders and ignoring that for some individuals, focusing on SUD could worsen PTSD symptoms. Second, the confrontational approach that is usually used in addiction settings can exacerbate PTSD and anxiety disorders. Third, twelve step programs often used by people with SUD do not encourage pharmacological interventions, causing an elevation in trauma symptoms. Fourth, a focus on SUD without giving much attention to the cause of these issues, usually trauma, can cause a regeneration of problems in the future [14]. Below is a vignette that is illustrative of some of the issues of a sequential model.

Linda had been using drugs since she was a teenager. She initially dropped out of school because of marijuana and alcohol abuse. She eventually became addicted to crack and cocaine as a young adult. Linda was molested by a maternal uncle from age five until she was an adolescent, but did not disclose the abuse. Because of her drug use, her three young children were removed from her custody and placed in foster homes. This motivated her to begin drug recovery. She attended a SUD program for three months and once this was completed she was referred for trauma-focused psychotherapy. In therapy, she began to "work" on her sexual abuse history. However, feelings of anger, loss, and grief soon surfaced and the need to self-medicate with illegal drugs became urgent. Even though her children were returned to her care, the intrusive images overpowered her coping skills and she soon found herself back on the street lighting a pipe to escape her traumatic memories. Clearly, the sequential model of recovery did not work for Linda. An integrated model would have allowed her to work on both SUD and PTSD simultaneously.

The concurrent model that focuses on an integration of SUD and PTSD treatment has begun to replace the sequential model. A major advantage of the concurrent model is that it addresses the trauma issues that may have led to the addiction concurrently with abuse treatment [9]. Several programs have been developed for integrated treatment of co-occurring disorders of PTSD and SUD. A few of these are briefly reviewed below (Table 1).

Cognitive Behavioural Therapy (CBT)

CBT approaches focus on a wide variety of coping strategies to reduce arousal and avoidance symptoms among individuals who have PTSD and SUD [15]. An 8-12 session integrated CBT program incorporating techniques such as psychoeducation, breathing retraining, relapse prevention, self-monitoring, and cognitive restructuring reduced comorbid PTSD and SUD among participants compared to individuals who solely received individual addiction counseling [10]. These results were not only sustained at three-month follow-up, but lowered rates of PTSD.

Seeking Safety (SS)

SS is a 25-session present-focused, manualized intervention that addresses co-occurring PTSD and SUD. The intervention integrates cognitive, behavioral, and interpersonal topics, and participants receive psychoeducation about the consequences of trauma, explore the links between trauma and substance use, and develop appropriate coping skills [16]. Of the integrated psychosocial treatments designed for PTSD and SUD, SS has received the most empirical attention. In its first randomized controlled trial, SS was compared to relapse prevention and treatment as usual with 107 low-income urban women [17]. Both SS and relapse prevention demonstrated the most significant improvement among participants compared to treatment as usual. However, improvement among those who received SS was not sustained over six and nine-month follow-up periods. A recent study evaluating SS's effectiveness for treating PTSD and substance use symptoms in 12 between-groups studies (N=1,997 participants) found medium effect sizes for SS decreasing symptoms of PTSD and modest effects for decreasing symptoms of substance use [18].

Trauma Affect Regulation: Guide for Education and Therapy (TARGET)

TARGET is a group intervention for PTSD and SUD [19]. It is manualized and provides a framework for safely processing PTSD and SUD without experiencing psychological symptoms of avoidance, hypervigilance, dissociation, or decompensation or compromising sobriety. The curriculum is completed in 10 or fewer sessions. In a randomized clinical trial study at three outpatient substance abuse clinics (N=213; 61% women; 89% low-income), TARGET was found to be superior to treatment as usual in maintaining sobriety and self-efficacy. Although there were few differences in outcomes between White and African American participants on most measures, White participants reported more changes in posttraumatic cognitions than minority participants.

Addictions and Trauma Recovery Integration (ATRIUM)

ATRIUM is a 12-week integrated program that combines cognitive-behavioral and relational treatment to focus on childhood trauma and interpersonal violence [20]. ATRIUM incorporates psychoeducational and expressive techniques, and provides training in relaxation and mindfulness. ATRIUM helps participants develop skills to actively stop negative automatic thoughts associated with re-experiencing symptoms and to develop more appropriate self-care and coping skills [21].

Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD)

CTPCD, designed to treat co-occurring PTSD and cocaine dependence, is delivered in 16 sessions over eight weeks in individual outpatient psychotherapy settings. The program combines imagery and *in vivo* exposure therapy for PTSD, and CBT for substance dependence [22]. The first five sessions focus on coping skills for cocaine dependence. The sessions that follow transition into exposure therapy and later combine CBT for the treatment of both PTSD and SUD. A 16-week treatment trial found that substance use did not increase and PTSD and

depressive symptoms decreased [23]. CTPCD was recently reformulated into Concurrent Prolonged Exposure [24].

Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE)

COPE is a relatively new treatment program that addresses PTSD and SUD co-morbidity disorders [25]. The program is delivered over 12 individual sessions, each lasting 90-mins and combines prolonged exposure and relapse prevention techniques [25]. COPE produces more favorable results by reducing PTSD symptoms compared to treatment as usual [24].

Trauma Recovery and Empowerment Model (TREM)

TREM was originally created for women who struggle with substance abuse and trauma, but was recently adapted for men [26] (M-TREM). TREM is conducted in 24 to 29 sessions and incorporates CBT techniques, psychoeducation, and effective coping skills [26]. Research supports the efficacy of the program, which is used in residential and non-residential substance abuse programs, correctional institutions, and community mental health settings [2,27].

Table 1: Illustration of Integrated Programs.

Program	Number of Sessions	Techniques	Results
CBT	8-12	Psychoeducation, cognitive restructuring	Results sustained at 3 month follow up
Seeking Safety	25	Psychoeducation, coping skills	Better than treatment as usual
TARGET	10	Psychoeducation, coping skills	Superior to treatment as usual
ATRIUM	12	Psychoeducation, self-care training	Favourable outcomes in developing coping
CTPCD	16	Coping skills, exposure therapy, CBT	SUD and PTSD symptoms decreased
COPE	12	Prolonged exposure, relapse prevention	Favourable compared to treatment as usual
TREM	24-29	CBT, psychoeducation, coping skills	Efficacious in residential programs

Conclusion

Empirically, CBT that includes prolonged exposure therapy shows the most promise in treating co-occurring PTSD and SUD. However, an integrated approach is key in positively influencing treatment outcomes. More research is needed to examine the duration, scope, timing, and combination of components for optimal integration of PTSD and SUD treatment. Programs that include psychoeducation and structure for both clients and providers are likely to be most effective. Working closely with clients to establish treatment goals and expectations, and deciding what approach is best, will play a major role in determining the success of any program. Future research needs to expand the many evidence-based and promising options for integrated PTSD and SUD treatments to determine their effectiveness with more diverse and ethnic minority women.

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